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JANUARY 1977
Volume 73, Number 1

THE OHIO STATE Medical Journal



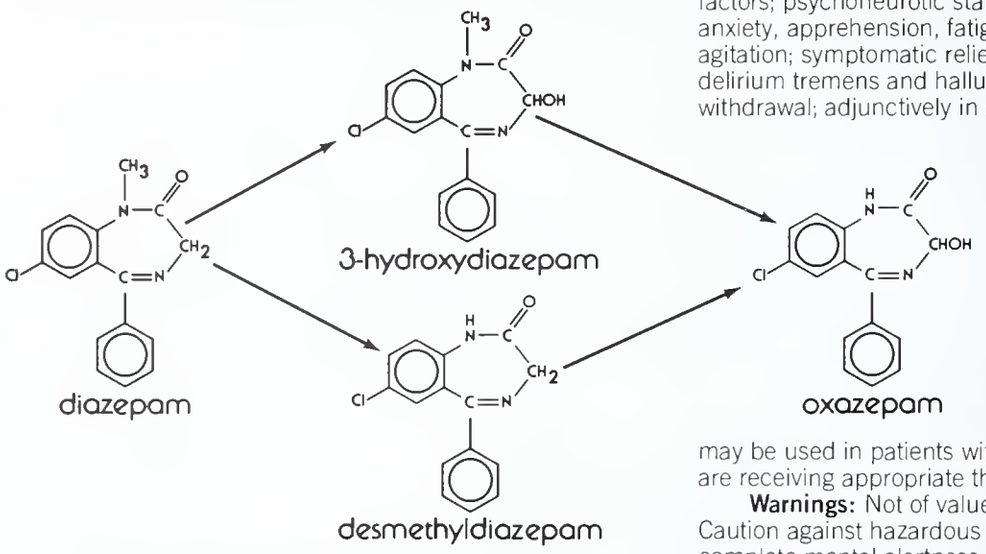
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REPORT ON THE 1976
AMA CLINICAL CONVENTION, PAGE 3

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Legislative Update

The 112th Ohio General Assembly convened January 4, 1977, with the Democrats holding veto-proof majorities in both the House and the Senate.

The Senate Democratic caucus has reelected the same leaders: Oliver Ocasek of Akron as senate president pro tem, M. Morris Jackson of Cleveland as assistant president pro tem, and Harry Meshel of Youngstown as majority whip. The Republican senators retained Michael J. Maloney of Cincinnati as minority leader and Paul E. Gillmor of Port Clinton as assistant minority leader, and named Thomas A. Van Meter of Ashland minority whip to replace Donald E. Lukens of Middletown.

In the House, Democrats increased their majority to 62-37, thereby joining Senate Democrats with sufficient party votes to override gubernatorial vetoes. The Democrats renamed Vernal G. Riffe of New Boston as speaker, Barney Quilter of Toledo as speaker pro tem, William Mallory of Cincinnati as majority floor leader, and Patrick A. Sweeney of Cleveland as assistant majority floor leader, and named Thomas Fries of Dayton majority whip. Republicans continued Charles Kurfess of Bowling Green as minority leader, Norman Murdock of Cincinnati as assistant minority leader, and Alan Norris of Westerville as minority whip.

A complete listing of the names and addresses of members of the Ohio General Assembly and Ohio members of the United States Congress is included in this issue of *The Journal* (see pages 51-53).

The OSMA strongly urges physicians to contact their local legislators to express both concern and support for legislative issues. This contact can be achieved both individually and collectively through the OSMA Department of State Legislation. The OSMA can be effective in the Ohio Legislature only if physicians assist with personal contact in their home communities.

The Ohio State Medical Association will focus its legislative efforts on three types of legislation: (1) licensing and registration bills; (2) revisions to previously enacted laws; and (3) legislative initiatives. The following lists indicate some of the legislation that will be considered in the 112th General Assembly.

Licensing and Registration Bills

1. Optometric Licensing— A proposal by the optometrists could include an expansion or redefinition of the practice of optometry.
2. Ancillary/Paramedical Group Licensing
3. Laboratory Registration
4. Hospital Licensing
5. Nursing Home Licensing
6. Lay Members on Licensing Boards
7. Revision of Medical Licensing Board
8. Separation of Physical Therapy from the State Medical Board— The creation of a Physical Therapy Board without mandatory physician representation.
9. Optician Licensing— Creation of a Dispensing Opticians' Licensing Board with both physician and optometrist membership.

Revision of Previously Enacted Laws

1. Medical Malpractice Act (HB 682)— Proposals include recommendations of the Governor's Task Force and the Legislative Service Commission.
2. Reexamination of HB 244, mental illness commitment procedures— Changes to make the law manageable within the framework of the practice of both medicine and the justice process.
3. PAP test requirement revision (HB 1000)— Making the law truly voluntary on the part of both the physician and the hospital.
4. Further regulations on delivery of emergency medical care.
5. Restructuring the Ohio Department of Welfare and creation of a Medical Service Bureau.
6. Revision of the new Worker's Compensation Law.
7. Revision of the new Medicaid bill.
8. Nurses Practice Act revision— A redefinition of the practice of nursing and its educational requirements.

Other Legislative Proposals

1. Medical Student Loan Commission— Establish a procedure of assisting the financial needs of Ohio's medical students.
2. Definition of Death— A Legislative Study Commission will make recommendations for legislation.
3. Physician Distribution— Another Legislative Study Commission will evaluate methods to attract physicians to under-serviced areas and to keep Ohio medical school graduates in Ohio.
4. Living Will
5. Patients Bill of Rights
6. Generic Drug Substitution— A major legislative effort by the Ohio Pharmaceutical Association will be made to repeal Ohio's current law restricting generic substitution.
7. Patients' Record and Privacy Bills.
8. Fluoride Restrictions
9. Osteopathic College Funding

Crime Victim Compensation Enacted

Legislation that provides compensation for losses suffered by crime victims passed tse Ohio General Assembly in 1976. House Bill 82 contains provisions that all physicians in Ohio should become aware of since implementation of the bill began December 28, 1976.

House Bill 82 authorizes compensation for economic losses suffered by victims of or persons attempting to prevent criminal conduct. The measure also covers the dependents of persons who are killed as a result of these crimes.

This law enables the victims of crime to be compensated for losses and allowable expenses as a result of their involvement. Included in the definition of allowable expenses is **the cost of medical care that a physician provides to the victim.**

House Bill 82 awards a maximum of $50,000 to any victim of a criminally injurious crime, providing it is a legitimate claim filed before one year elapses from the date of the incident.

The legislation provides for the appointment of at least three Court of Claims commissioners with exclusive jurisdiction to make awards. The State of Ohio Court of Claims is given exclusive and final jurisdiction to hear appeals from decisions rendered by the Court of Claims commissioners.

The State Attorney General is required to investigate all applications before the commissioners' hearing. The Attorney General's Office determines the validity of the application, examines whether or not the claimant was an innocent victim of the crime, and recommends the amount of expenses resulting from the claimant's injuries.

The Attorney General's investigator also determines the amount of compensation that the claimant should receive by determining what expenses are not covered by collateral sources such as health insurance, disability insurance, and the like.

The Attorney General's Office has advised the OSMA that as part of their investigation, they will be calling upon physicians to provide information concerning the extent of injuries and the medical bills incurred as a result of the injuries. The State of Ohio will pay either all the valid medical expenses or the portion that other medical insurance does not cover. The claimant and the physician to whom the expenses are owed will be served by prompt response by the investigators.

A claim is commenced by the victim filing an application for an award of reparations within one year after the occurrence of the criminally injurious conduct that is the basis of the claim. The application is filed either in the Court of Claims or the Court of Common Pleas in the county of residence. Once this has been done, the examination begins; and, ultimately, payment on legitimate claims is made by the State of Ohio.

Physicians should work closely with the Attorney General's investigators to avoid complications in the payment for services they have rendered to persons eligible for compensation under H.B. 82.

OSMA Adds Fed.-Legislation Dept.

The OSMA is leading the way in strengthening national legislative efforts on behalf of the medical profession. During the 1975 AMA Clinical Convention, a resolution was adopted that encouraged state associations to create departments of federal legislation so that national, state, and local efforts in federal legislation could be coordinated. This same topic was reintroduced at the 1976 AMA Clinical Convention. (See "Report of Proceedings AMA 1976 Clinical Convention," page 3 this issue.) At the December 1976 meeting of the OSMA Council, such an independent OSMA department was formed.

Charles W. Edgar, who has handled federal legislation along with his duties as OSMA Director of Public Relations, was appointed Director of the Department of Federal Legislation and Public Policy.

In addition to the development of this department, there have been several other OSMA staff changes. Rebecca J. Doll, OSMA Manager of Media Relations, has been appointed Director of the Department of Communications. The Department of Continuing Medical Education saw the resignation of Douglas C. Houser, who has returned to school to complete his graduate degree.

Richard A. Ayish has joined the OSMA staff as Assistant Director of the Department of State Legislation. My Ayish, who received his bachelor of science degree in journalism from Ohio University and his master's degree in public administration from the University of Toledo, has most recently been employed in the Ohio Legislative Internship Program. He served as a legislative assistant in the Ohio House of Representatives with duties which included legislative research and analysis; budgetary analysis; constituent case work; and writing speeches, newsletters, and press releases. Mr. Ayish was also an administrative intern for the City of Toledo during the time he was completing the requirements for his master's degree.

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Deadline for Resolutions to be Considered at 1977 OSMA Annual Meeting March 16

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Report of Proceedings AMA 1976 Clinical Convention

Philadelphia, Pennsylvania, December 4-8, 1976

Linda A. Jacobson

The American Medical Association Clinical Convention held in Philadelphia in December marked the 30th and last assembly of this nature. In the future, the AMA will sponsor regional continuing medical education meetings. The AMA House of Delegates, which in the past met in conjunction with the Clinical Convention, will in the future meet in the late fall each year in Chicago. The Annual Meeting of the AMA, and the simultaneous meeting of the House, will continue to be held in early summer each year at locations selected by the AMA.

Delegates to the AMA House of Delegates are chosen by states on a basis of one delegate for every 1,000 physicians. Additionally, one delegate is chosen to represent each specialty area. Thus, both state organizations and specialty groups have representation in the House. Ohio was represented in Philadelphia not only by its delegates, elected by the OSMA House of Delegates, but also by physicians from Ohio elected by various specialty societies.

AMA Delegates representing Ohio were Oscar W. Clarke, M.D., Gallipolis; Henry A. Crawford, M.D., Cleveland; Harry K. Hines, M.D., Cincinnati; W. J. Lewis, M.D., Dayton; Richard L. Meiling, M.D., Columbus; H. William Porterfield, M.D., Columbus; P. John Robechek, M.D., Cleveland; Robert N. Smith, M.D., Toledo; and Robert E. Tschantz, M.D., Canton.

Alternate Delegates were John E. Albers, M.D., Cincinnati; George N. Bates, M.D., Toledo; Dwight L. Becker, M.D., Lima; Richard L. Fulton, M.D., Columbus; John J. Gaughan, M.D., Cleveland; Jerry L. Hammon, M.D., West Milton; Bernard L. Huffman, M.D., Maumee; Jack Schreiber, M.D., Canfield; and Robert G. Thomas, M.D., Elyria.



The Ohio Delegation to the AMA House of Delegates (left to right) Top Row: H. William Porterfield, M.D.; Jerry L. Hammon, M.D.; Robert E. Tschantz, M.D.; and Oscar W. Clark, M.D. Bottom Row: Henry A. Crawford, M.D.; W. J. Lewis, M.D.; Richard L. Meiling, M.D.; and P. John Robechek, M.D.



AMA Ohio Delegation Chairman P. John Robechek, M.D., (left) and Alternate Delegate Jerry L. Hammon, M.D.

Also from Ohio were AMA President-Elect John H. Budd, M.D., Cleveland; Ophthalmology Delegate Charles E. Jaeckle, M.D., Defiance; Obstetrics and Gynecology Alternate Delegate Richard T. F. Schmidt, M.D., Cincinnati; and Cardiovascular Diseases Delegate William A. Sodeman, M.D., Toledo. John W. Moses, M.D., who just moved to Akron, Ohio, from Detroit, was in attendance as a member of the Council on Medical Education.

Doctors Meiling and Tschantz were honored by the House of Delegates in recognition of their forthcoming retirement from the Ohio Delegation. In addition, the Ohio Delegation launched its campaign to elect Jack Lewis, M.D., to the position of Vice Speaker of the AMA House of Delegates. The election will take place at the 1977 AMA Annual Meeting held in June.

The House of Delegates, which functions as the governing body of the AMA with power vested in the Board of Trustees when the House is not in session, convened the afternoon of December 5, 1976. Reference committee hearings were held on December 6 with reports to and action taken by the House occurring on December 7 and 8. Oscar W. Clarke, M.D., served as chairman of the Reference Committee on Amendments to the Constitution and Bylaws; and Robert E. Tschantz, M.D., was a member of Reference Committee D on hospitals and medical facilities. Also, the various councils of the AMA met during this time. In addition to Dr. Moses, Ohio has representatives on the Council on Continuing Physician Education (John E. Albers, M.D.) and the Council on Scientific Affairs (Richard T. F. Schmidt, M.D.).

(continued on page 4)

AMA Clinical Report *(continued)*



AMA President-Elect John H. Budd, M.D., Cleveland, addresses the House during the report of Reference Committee D. Ohio's Robert E. Tschantz, M.D., seated second from left in lower portion of photograph, served as a member of this committee.

Opening Ceremony

Milton M. Perloff, M.D., President of the Philadelphia County Medical Society, welcomed the AMA Delegates by noting that Philadelphia hosted both the founding of the United States and the founding of the American Medical Association.

Tom E. Nesbitt, M.D., Speaker of the House of Delegates, also greeted the attendants. He noted that this meeting of the House marked a trial attempt at providing the alternate delegates the opportunity to speak on the floor of the House whether or not they were seated to vote. This change was necessitated by the fact that many delegations use their alternates to cover reference committees; and, therefore, the alternates become the well-versed spokesmen from the delegations. Dr. Nesbitt also stressed the need for delegates to communicate to their colleagues at home the actions of the AMA House. Needed communication, the Speaker stated, is evident in the lack of understanding many physicians have for the AMA and its function.

AMA President Richard E. Palmer, M.D., advocated joint protection of the patient and the physician as the AMA goal for any type of future national health insurance. Should any program be enacted, he noted, it must also be administratively and fiscally prudent. Dr. Palmer urged all physicians to continually "Go forward, my friends, always go forward." Upon completion of his remarks, Dr. Palmer presented the Dr. Benjamin Rush Bicentennial Award to Mario E. Rameriz, M.D., of Texas. A $5,000 stipend and medallion honored Dr. Rameriz for his work. In accepting the award, Dr. Rameriz remarked that he had been a member of the AMA for 26 years and had never regretted his membership. The AMA, he said, is the body most knowledgeable of medical problems.

James C. MacLaggan, M.D., Chairman of the Board of the American Medical Political Action Committee (an independent group of physicians), reported on the 1976 National Election campaign. The year 1976 marked the ninth all-time-high membership year and included a 15 percent increase over 1975 membership. Women comprise 20 percent of the membership. Over the two-year period leading up to the November 1976 election, AMPAC contributed in excess of $1 million to campaigns for federal office. Contributions were made to 350 candidates for the House of Representatives and 40 candidates for senatorships. Of those who received contributions, 73 percent won their races.

The report on the AMA Education and Research Foundation (AMA-ERF) was given by James M. Black, M.D., president of the foundation. He noted that AMA-ERF had provided 4,315 loans to medical students during the first ten months of 1976. These loans amounted to in excess of $6 million. Currently, the AMA has approximately $40 million in AMA-ERF loans outstanding. Each dollar contributed underwrites $12.50 in loans. Dr. Black emphasized that the funds underwriting these loans came entirely from the medical profession. "This is a fact that makes me proud," he said. He continued his praise in saying: "The Auxiliary effort in support of AMA-ERF is truly inspiring."

Office of V-P Abolished

One of the initial pieces of business of the House was the abolition of the office of AMA vice president. The line of succession to the AMA presidency will now be president-elect to president, should the latter be unable to complete a term. Under such a succession, the president-elect will also be allowed to serve his elected term even though he has to fill an unexpired term of a president.

(continued on page 6)



Speaker Tom E. Nesbitt, M.D., assists Ohio Alternate Delegate Jack Schreiber, M.D., during the opening ceremony.

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.**, and **D. H. Perez, M.D.**: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Delegate Loss and Full-Time President Topics of Discussion

The Reference Committee on Amendments to Constitution and Bylaws heard a resolution concerning the procedure that state associations should follow when the number of delegates to the AMA is reduced due to fluctuation in membership from that state. This resolution is of interest to Ohio as the AMA membership has declined; and as a result, Ohio has lost one delegate and one alternate delegate to the AMA effective January 1977.

It was decided by the House of Delegates that, when a fluctuation of membership causes a loss of one or more delegates, the state association will determine for themselves which delegates will serve in the remaining seats.

Another topic that came before this committee was the concept of a full-time AMA president. The sponsor of this resolution stated that his objective was to accomplish for medicine, "one clear voice" which would be easily recognizable and instantly identifiable. Continuity was also described as a necessary quality for maximum effectiveness of the AMA. Support at the reference committee hearing for the basic concept underlay the recommendation that the resolution be referred to the Board of Trustees and through the Board to the Council on Long Range Planning and Development for further study. A report was requested for the 1977 AMA Annual Meeting. The House of Delegates supported this referral.



Ohio opened its hospitality suite in honor of candidate Jack Lewis, M.D. Hosts included (left to right): Delegate H. William Porterfield, M.D.; OSMA staff member Jerry J. Campbell; and Delegate Robert N. Smith, M.D.



Also in attendance at the Clinical Convention were county society staff members including (left to right): Toledo's Lee F. Wealton and Earl E. Shelton of Dayton.

"Primary Care" Defined

Reference Committee A handled a number of resolutions that were hotly debated on the floor of the House. One such topic dealt with the definition of the medical area known as "primary care." The Council on Medical Service, in Report E, responded for the second time to a 1975 resolution asking that the major "primary care specialties" be identified by the AMA. Testimony before the reference committee reemphasized the concerns expressed in previous years that the identification not preclude direct access by patients to physicians in other specialties. In addition, the remarks emphasized the importance of recognizing that primary medical care can be provided only by a physician.

The House adopted the report of the Council on Medical Service which read in part:

> The definitions or descriptions of primary care suggested by many . . . seem in general agreement on the three essential elements which comprise such care: (a) initial access to health services; (b) continuing patient-centered responsibility for comprehensive care including prevention; and (c) coordination of other care resources needed by the patient.
>
> The Council on Medical Service believes that the specialties of family practice, internal medicine, obstetrics and gynecology, and pediatrics do constitute the major although certainly not the sole components of the profession which, together with general practice, provide this type of care for the public. At the same time, the Council fully concurs with the need to ensure continued direct access to physicians in other specialties.

Medicare-Fee Profiles Lower for Rural Physician

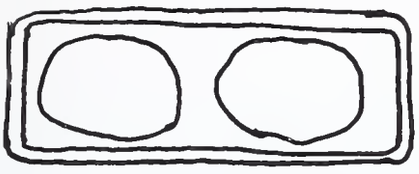
Medicare-fee profiles also were considered by this committee. A resolution urged the AMA to exert strong influence on the Bureau of Health Insurance of the Social Security Administration to reestablish equitable payment mechanisms for physicians under the Medicare law. Testimony before the committee reinforced the need for such efforts, which have, in fact, been underway for some time.

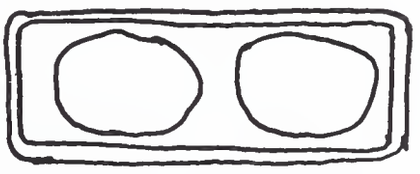
On the floor of the House, delegates emphasized the fact that division of states into geographical areas for payment purposes under Medicare results generally in lower fees for rural physicians; and since lower fees tend to produce a negative incentive to physicians to locate

(continued on page 8)

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AMA Clinical Report *(continued)*

in rural and thinly populated areas, the AMA should make every effort to remove the statutory and regulatory requirements for delineation of fees according to geographical areas. The House referred the entire question of Medicare-fee profiles to the Council on Medical Services and asked that a report be made at the 1977 Annual Meeting.



Meeting at an early morning, Ohio Delegation caucus are Harry K. Hines, M.D., (left) and John J. Gaughan, M.D.

Medicaid Fraud and Abuse

Another topic that received considerable discussion was Medicaid fraud and abuse. The House adopted the following resolution concerning this matter:

Resolved, That the AMA condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provision of due legal process of all who are charged with fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities.

Resolved, That the AMA continue to protest vigorously improper and/or undocumented accusations of abuse and/or fraud made against physicians by government, news media, and others.

National Health Insurance Draws Longest House Debate

The most hotly debated topic was national health insurance as differentiated from national health services. Six resolutions and reports of the Board of Trustees and the Council on Medical Service were concerned with AMA policy on national health insurance. The resolutions variously called upon the AMA to continue to sponsor federal legislation embracing the principles expressed in HR 6222, as introduced in the 94th Congress; to introduce no national health legislation; to withdraw support for HR 6222 and to mount a national public education program on the "predictable results of any socialized medical scheme"; to oppose all governmentally mandated national health insurance plans thus far proposed; and neither to design nor to sponsor any health care program in which federal administration or financing is a part.

The House adopted the reports of the Board of Trustees and the Council on Medical Service which support HR 6222. The reference committee reported that this bill "embodies all principles approved by this House and represents a viable mechanism to advance the Association's views on this subject . . . (and commended) the positive approach by the Association in advancing a national health insurance proposal."

The terms of the bill include being mandatory only as to employers. The title does not carry the designation "national health insurance," which is objectionable to many. It is named the "Comprehensive Health Care Insurance Act of 1975." Additionally, changes have been made in the proposed Health Insurance Advisory Board, the overseer of the plan, to increase the majority of health professionals on the board, to alter the manner of selection of the chairman and the appointment of advisory committees, and to change the name of the board.

Reference Committee B also considered the AMA legislative program with emphasis on developing a federation concept so that state and local societies would become active and influential in national legislation. This particular idea, initiated at the 1975 Clinical Meeting, involves encouraging state societies to establish federal legislative departments to coordinate local and national efforts. The OSMA has just reorganized to establish such an independent department to focus on the national legislative issues. (See Legislative Update, this issue.)

Medical Student Liability

An issue considered by Reference Committee C was that of medical student liability in instances when he spends part of his training at an institute other than that at which he is enrolled. Timothy Hosea, a student at the University of Cincinnati College of Medicine, presented



Oscar W. Clarke, M.D., (left) listens as University of Cincinnati medical student Timothy Hosea presents proposals of the AMA Student Business Session to the Ohio Delegation.



Ohioan Charles E. Jaeckle, M.D., the Ophthalmology Delegate, was a proponent of a change in the Medicare-fee profiles.

this question to the Ohio Delegation in caucus. Testimony to the reference committee confirmed the existence of the problem, but also indicated serious limits to the feasibility of the requested action. Therefore, the House passed a resolution urging every medical school to try to make comprehensive liability coverage available to its students while they are participating in the core curriculum of their respective medical schools or extensions of this curriculum that have been approved by the deans of their respective medical schools. In addition, the matter was referred to the Board of Trustees and from it to the Council on Medical Education for study and early report back to the House.

Guidelines for Various Hospital Privileges Discussed

A Board of Trustees report on unions was adopted by the House. This report calls for reaffirmation of the policy that the AMA aid and assist interns and residents in conflict with hospitals; that this assistance be rendered on merit in the form of advice, counsel, and even financial support; but that it *not include endorsement of collective bargaining through trade unionism.*

Another resolution concerned hospital staff membership by podiatrists. The Council on Medical Service recommends retention of the present Joint Commission on Accreditation of Hospitals policy that states "medical staff membership shall be limited to individuals who are fully licensed to practice medicine and, in addition, to licensed dentists." The House adopted the report in which this recommendation appears.

Two resolutions concerned admission of patients to hospitals under the primary responsibility of qualified physicians and hospital privileges of non-physician providers of health care. These resolutions were intended to improve the standards of patient care provided in the hospital setting. The reference committee received information pertaining to the issues of hospital privileges for non-physician providers of health care in today's legal climate. The complexity of the legal issues and the limited amount of time available for deliberation by the committee and the House necessitated referral of the problem to the Board of Trustees with a report back to the House at the 1977 Annual Convention.

Terminal Illness

The House adopted a resolution asking that the Judicial Council Report on Euthanasia and Terminal Illness be referred back to the Council with a request that a report on terminal illness be submitted to the House at the 1977 Annual Convention addressing the role of governmental bodies in such matters. This resolution supported the majority opinion that state legislatures should not be involved in determining when life-sustaining measures should be terminated.





Left: Delegate and Consulting Medical Editor of *The Journal* Richard L. Meiling, M.D. Right: Cleveland physician Theodore Castelle, M.D., who sat in at all Ohio caucus sessions.

House Considers Prescribed Drugs

The House addressed the question of the drug amygdalin (Laetrile). A resolution was passed mandating the AMA to inform the public of the danger of delay in the diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective. In addition, the Association will inform the public that the safety and efficacy of amygdalin for the treatment or palliation of malignancies is unproven and that the use of the drug in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, in some cases for the profit of the unscrupulous.

Generic substitution of a prescribed drug was also discussed. The reference committee heard general support for the concept of anti-substitution laws and opposition to substitution at the discretion of pharmacists. The House passed a resolution reaffirming the AMA position of opposition to revision of state laws and pharmacy regulations that prohibit unauthorized substitution of prescription drug products as contrary to the public interest. Additionally, the resolution asked physicians to supple-

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AMA Clinical Report *(continued)*

ment medical considerations with cost considerations in making a drug selection for a patient. When a physician desires to delegate selection of the source of a particular drug to the pharmacist, he should write the prescription using the generic name or the notation "generic substitution allowed."

Direct Billing

An issue that divided AMA and state and local societies is that of direct billing by the AMA for its dues. The House adopted a recommendation that state and county societies who have raised objections to such a billing system relate such objections to the Board of Trustees within 60 days from the 1976 Clinical Meeting. The Board will then deliberate on the issues. Also, the House adopted a recommendation that all medical societies that have the responsibility for billing for the AMA make whatever changes are necessary in their procedures to assure the prompt forwarding of all AMA dues to the AMA.



OSMA President George N. Bates, M.D., (left) and staff member Robert Holcomb greeted guests in the hospitality suite.

Support for Office Of Surgeon General

Reference Committee G heard discussion on the reestablishment of the office of the Surgeon General of the U.S. Public Health Service. The House adopted a resolution supporting this concept.

Delegate to Represent Section on Medical Schools

The Constitution and Bylaws were amended by unanimous House of Delegates action to establish a "Section on Medical Schools" which will represent each medical school in the U.S. This section will elect one delegate and one alternate delegate to the House.



Left to right: Delegates Robert N. Smith, M.D., and Henry A. Crawford, M.D., at an Ohio caucus.

The section will include the dean of each medical school, providing he is an active member of the AMA. If the dean is not an active member of the AMA or is not a physician, he can designate a member of his faculty who is an active member of the AMA to represent his school.

Not more than five additional members of the faculty or administration of each approved medical school, who are also active members of the AMA, may be designated by the dean of each medical school to be members of the Section on Medical Schools.

Legal Issues

Finally, The House discussed what input the AMA could have in legal issues encountered by state and county societies. It was determined that the AMA would provide assistance in research of questions and advice on procedure, but that it could not support legal encounters monetarily.

In addition, the House adopted the Board of Trustees' recommendations on professional liability as pertains to tort reform and patient compensation systems as avenues to most effectively handling the liability crisis. The House also asked that the subject be addressed again at the 1977 Annual Meeting with particular emphasis on the American Medical Assurance Company, which will provide reinsurance for physician-owned malpractice liability insurance companies established by the federation.

Further information concerning the 1976 AMA Clinical Convention is available by contacting the OSMA Headquarters Office, 600 South High Street, Columbus. Telephone: 614/228-6971.

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COLLEAGUES IN THE NEWS . . .

Columbus Physician President Am. Academy of Physical Medicine

ERNEST W. JOHNSON, M.D., Professor and Chairman of the Department of Physical Medicine of the Ohio State University College of Medicine, was recently installed as President of the American Academy of Physical Medicine and Rehabilitation at the Academy's 38th Annual Assembly. Dr. Johnson joined the faculty at Ohio State in 1954 as an Instructor in Anatomy, became an Assistant Professor in Physical Medicine and Rehabilitation in 1957, was promoted to Associate Professor and Director of the Division of Physical Medicine and Rehabilitation in 1959, and was named Professor and Chairman of the department in 1963. He also serves as Associate Dean of Ambulatory Programs for the College of Medicine.

Past President of both the American Association of Electrondiagnosis and Electromyography and the Ohio Society of Physical Medicine and Rehabilitation, Dr. Johnson is currently President-Elect of the Association of Academic Physiatrists. In addition, he serves, or has served, on the Medical Advisory Committee to the Ohio Department of Welfare and the Rehabilitation Study Commission of Ohio.

The Ohio State University has bestowed a number of honors on Dr. Johnson. He was named "Man of the Year" by the College of Medicine's graduating class of 1968; and he is the recipient of the Alumni Centennial Award (1970) and the Alumni Achievement Award (1972). In addition, he is the editor of the Ohio State University College of Medicine *Journal.*

Dr. Johnson also serves as president of the Miss Wheelchair America pageant, an annual event held in Columbus. In 1972, he was selected to receive the coveted Gold Key Award of the American Congress of Rehabilitation Medicine for "outstanding contributions" to the advancement of the science of physical medicine and rehabilitation.

Five Ohio physicians have been granted Fellowship in The American College of Cardiology, the national medical society for specialists in cardiovascular diseases. Those admitted to the college's highest membership classification are **JOHN E. ALBERS, M.D.,** Cincinnati; **RANENDRA L. DasVARMA, M.D.,** Akron; **ABDALLA EZZIDDIN, M.D.,** Cleveland; **RICHARD A. MEYER, M.D.,** Cincinnati; and **STEPHEN F. SCHAAL, M.D.,** Columbus.

RALPH J. ALFIDI, M.D., has been elected president of the Cleveland Radiological Society. Other officers are **CHARLES M. GREENWALD, M.D.,** president-elect; and **JOHN B. McCOY, M.D.,** secretary-treasurer.

HAROLD J. BARKER, M.D., Cleveland Heights, was presented the Physician of the Year award at the annual meeting of Suburban Community Hospital. Dr. Barker was cited for his service on the hospital's peer review, medical records, and emergency and trauma committees.

JOHN R. BAY, M.D., Oberlin, has been elected to membership in the American College of Emergency Physicians. Dr. Bay is employed in the emergency department of St. Joseph Hospital, Lorain.

A. ROBERT DAVIES, M.D., Dayton, has been appointed Associate Professor of Medicine and Director of the Group in Internal Medicine, Wright State University School of Medicine. Dr. Davies previously served as Chief of Staff at both Stouder Memorial Hospital and Dettmer Hospital, Troy. He assisted in establishing active intensive care units in both hospitals.

Wright State University School of Medicine has named three voluntary clinical faculty members to head its Department of Medicine Group in Cardiology. **PAUL W. GRUNENWALD, M.D.,** Associate Clinical Professor; and **BENJAMIN SCHUSTER, M.D.,** and **SYLVAN L. WEINBERG, M.D.,** Clinical Professor, will serve as co-directors of the group.

These physicians' main responsibilities will be to institute fellowship programs in cardiology; to create and to implement the undergraduate curriculum in cardiovacular disease; and to develop the cardiovascular teaching content of educational programs in internal medicine, family practice, and other specialties.

KENNETH R. KATTAN, M.D., has joined the Dayton Veterans Administration Center as Assistant Chief of Radiology Service. He will also serve as Professor of Radiological Sciences at the Wright State University School of Medicine. Dr. Kattan was formerly Director of the Department of Radiology at Drake Memorial Hospital, Cincinnati, and Associate Professor of Radiology at the University of Cincinnati College of Medicine.

FLORENCE K. MATTHEWS, M.D., Cleveland, has been elected president of the medical staff of Woodruff Hospital. Serving as vice-president will be **HENRY GOLDHIRSCH, M.D.;** and **SIGMOND M. CHA, M.D.,** will be secretary.

WILLIAM P. MONTANUS, M.D., Springfield, was presented the "Physician of the Year" award at a recent Clark County Medical Society meeting. A Springfield surgeon for 30 years, Dr. Montanus is Director of the Mercy Medical Center Chemotherapeutic Clinic and

chairman of the medical society's cancer review committee. Also a past president of the society, he is a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, and a member of the Central Surgical Association.

ALAN R. MORITZ, M.D., Cleveland, is the newly elected Chairman of the Board of Trustees of Hillcrest Hospital, Mayfield Heights. Dr. Moritz is the 1976 recipient of the Medical Mutual Honor Award in recognition of his outstanding contributions to the field of forensic pathology. He is a former provost of Case Western Reserve University and has served as president of the American Academy of Forensic Sciences.

ARTHUR J. NEWMAN, M.D., and **LeROY W. MATTHEWS, M.D.,** Cleveland, have been honored by the Pediatric Clinical Faculty of Rainbow Babies and Children's Hospital, the Children's Medical and Surgical Center of University Hospitals of Cleveland. Dr. Newman, Associate Professor of Pediatrics at Case Western Reserve University, received the second annual Golden Stethoscope Award for outstanding contribution to clinical pediatrics. Creed F. Ward, M.D., of the Pediatric Clinical Faculty executive committee, said of Dr. Newman: "He has with expressive clarity consistently brought practical understanding of academic material to the arena of clinical application."

Dr. Matthews, Professor of Pediatrics at Case Western Reserve University, was honored for his conception and support of the Pediatric Clinical Faculty which has grown from 29 member to 70 members since it was organized in 1972. Dr. Matthews was the first recipient of the Golden Stethoscope Award.



Left to right: Arthur J. Newman, M.D., receiving the Golden Stethoscope Award from Creed F. Ward, Sr., M.D., and Henry Saunders, M.D.

JOEL G. SACKS, M.D., of Northwestern University Medical School, Chicago, has been named Professor and Director of the Department of Ophthalmology at the University of Cincinnati College of Medicine. This appointment is effective July 1, 1977, when Dr. Sacks will also become Chief of Ophthalmology at the University of Cincinnati Medical Center Hospitals. Currently Associate Professor of Ophthalmology and Neurology at Northwestern, Dr. Sacks is a specialist in clinical ophthalmology and neuro-ophthalmology. He has served as a National Institutes of Health Special Fellow in Neuropathology and a Senior Research Fellow at The Johns Hopkins Hospital Wilmer Ophthalmological Institute. Certified by the American Board of Ophthalmology, Dr. Sacks is a member of the American Academy of Ophthalmology and Otolaryngology, the American College of Surgeons, and the Association for Research in Vision and Ophthalmology.

R. S. SCHERBARTH, M.D., Toledo, has been appointed director of the family practice residency program at Flower Hospital. Dr. Scherbarth has served as chief of general practice and chief of staff at the hospital.

WILLIAM M. SINGLETON, M.D., West Portsmouth, is the recipient of a coveted Alumni-of-the-Year Award bestowed by West Virginia Wesleyan College. Dr. Singleton was the first student at West Virginia Wesleyan to letter in four sports.

JOSEPH TORI, M.D., Warren, has been named medical director of General Motors Packard Electric Diviison at Warren. Dr. Tori is leaving the General Motors Assembly Division facility in Wilmington, Delaware, where he has served as medical director since 1968. A family practitioner until joining General Motors, Dr. Tori is a member of the American Academy of Family Practice and is a Fellow of the Occupational Medical Association.

ROBERT S. YOUNG, M.D., Johnson, gave the keynote address at the fifth annual "Careers in Medicine Symposium" sponsored by Muskingum College. Dr. Young, who spoke on "Family Practice and You," is the senior delegate from Ohio to the American Academy of Family Physicians and a past president of the Ohio Academy of Family Physicians. In addition, he serves as medical editor of the publication, *Your Doctor Reports.*

Also participating in the two-day program which acquainted high school students with the career options in the field of health care and the educational requirements necessary to succeed in them were **CARL E. SPRAGG, M.D.,** New Concord; and **WILLIAM S. QUIGLEY, M.D.,** Cambridge. Dr. Spragg was a member of a panel of professionals representing several health fields who discussed their medical work and educational background for the students. Chief of Radiology and Nuclear Medicine at Guernsey Memorial Hospital, Dr. Quigley gave the closing address at the symposium.

VERNON V. WOOD, M.D., Ironton, has been honored by the Southeastern Ohio Regional Council. A general practitioner, Dr. Wood is one of 11 individuals selected by their communities for this honor due to their contributions to their respective communities.

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CONTINUING EDUCATION

(Editor's Note: Items for this calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed below.)

Periodic Programs

GRAND ROUNDS AND EDUCATIONAL CONFERENCES: Every Friday, 12:00 noon; Licking Memorial Hospital, Newark; sponsor: Licking Memorial Hospital; 1 credit hour; contact: Ralph E. Pickett, M.D., Vice President, Medical Affairs, Licking Memorial Hospital, 1320 West Main St., Newark 43055, phone: 614/344-0331, ext. 397.

PEDIATRIC GRAND ROUNDS: Friday, each week except holiday weeks; Mount Sinai Hospital Auditorium, House Staff Dormitory, Cleveland; sponsor: Department of Pediatrics, Mt. Sinai Hospital; 1 credit hour; contact: Dr. Arnold B. Friedman, Mt. Sinai Hospital, University Circle, Cleveland 44106, phone: 216/795-6000, ext. 236.

SURGERY LECTURE SERIES: 2nd, 3rd, and 4th Saturday, each month, 8:30 AM; House Staff Residence Auditorium, Mt. Sinai Hospital, Cleveland; sponsor: Department of Surgery, Mt. Sinai Hospital-CWRU School of Medicine; 1½ credit hours per session; contact: Dr. James P. Weaver, Department of Surgery, Mt. Sinai Hospital, Cleveland 44106, phone: 216/795-6000.

Single Course Offerings

January 1977

CME AT RIVERSIDE METHODIST HOSPITAL: January 25, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: January 25, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medi-Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: January 26-27; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 11¾ credit hours; fee: $80; contact: Education Department, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

February 1977

INFECTIOUS DISEASE: February 1, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

INFECTIOUS DISEASE CONFERENCE: February 2; Fawcett Center, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine Center for Continuing Education; 6 credit hours; fee: $45; contact: OSU College of Medicine, Center for Continuing Education, A-352 Starling Loving Hall, 320 W. 10th Avenue, Columbus 43210, phone: 614/422-4985.

CONTINUING MEDICAL EDUCATION CONFERENCE: February 5 and 19; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Blvd., Springfield 45501, phone: 513/399-7121, ext. 341.

CARDIOVASCULAR PATIENT CARDIAC REHABILITATION PROGRAMS (Evaluation of): February 8, 8:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: February 8, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CONSULTATION LIAISON IN PSYCHIATRY: February 12-13; Marriott Inn—I-75, Cincinnati; sponsor: University of Cincinnati Medical Center; cosponsor: Ohio Psychiatric Association; 7¾ credit hours; fee: $20 members ($30 nonmembers); contact: Roslyn Seligman, M.D., Ohio Psychiatric Association, 88 East Broad Street, Columbus 43215, phone: 614/872-5169.

NORMAL AGING-CREATIVE INTERVENTION: February 14-18; Stouffer Dayton Plaza, 5th & Jefferson St., Dayton; sponsor: Postgraduate Medicine, Department of Medicine and Community Medicine of Wright State University School of Medicine; cosponsor: VA, Central State University, and Scripps Foundation of Miami University; 24 credit hours; fee: $195; contact: John C. Barton, Ph.D., Wright State University, Department PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

PERITONITIS (New Look at): February 15, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

EAR, NOSE AND THROAT PROBLEMS (Practical Management of): February 16; Fawcett Center, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine Center for Continuing Medical Education; 5 credit hours; fee: $45; contact: OSU College of Medicine, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210, phone: 614/422-4985.

COMPUTED TOMOGRAPHY OF THE HEAD AND BODY: February 16-17; Bunts Auditorium, Cleveland Clinic Educational Foundation; sponsor: Cleveland Clinic Educational

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CONTINUING EDUCATION

(continued from page 15)

Foundation; 12 credit hours; fee: $175 ($100 residents-interns); contact: Rosalind Presby, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: February 22, 7:30 AM; Riverside Methodist Hospital, Columbus, sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NEOPLASIA LYMPHADENOPATHY: February 22, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CURRENT TOPICS IN CLINICAL MICROBIOLOGY: February 23-24; Cleveland Clinic Foundation; sponsor: Cleveland Clinic Educational Foundation; cosponsor: American Medical Association; 12 credit hours; fee: $80 ($40 residents); contact: Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

March 1977

CONTINUING MEDICAL EDUCATION CONFERENCE: March 5 and 19; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Blvd., Springfield 45501, phone: 513/399-7121, ext. 341.

NUCLEAR MEDICINE: March 7-11; Nuclear Medicine Institute, Hillcrest Hospital, Cleveland; sponsor: Nuclear Medicine Institute; 40 credit hours; fee: $500 ($200 resident); contact: D. Bruce Sodee, M.D., Director, 6780 Mayfield Rd., Cleveland 44124, phone: 216/449-4500, ext. 370.

MEDICAL PROGRESS AND ITS RELATIONSHIP TO DENTISTRY: March 16-17; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 10 credit hours; fee: $50 ($25 resident); contact: Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

SYMPOSIUM ON APPROACHES TO PAIN: March 19-20; Stouffer's Dayton Plaza Hotel, Dayton; sponsor: Wright State University School of Medicine; cosponsor: Dept. of Postgraduate Medicine and Mercy Medical Center, Springfield; 11 credit hours; fee: $75; contact: Arlene Polster, Program Coordinator, Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/429-3200, ext. 376.

12TH ANNUAL CANCER SYMPOSIUM: March 23-24; Akron City Hospital, Akron; sponsor: Akron City Hospital; 10½ credit hours; fee: $50 ($10 students); contact: Debbie Harwell, Akron City Hospital, 525 E. Market St., Akron 44309, phone: 216/375-3202.

TEACHING AND YOUR PRACTICE: March 26-27; Marriott Inn, Columbus; sponsor: Ohio Academy of Family Physicians; 8¾ credit hours; fee: $50 ($25 AAFP residents); contact: Ohio Academy of Family Physicians, 4075 North High St., Columbus 43214, phone: 614/267-7867.

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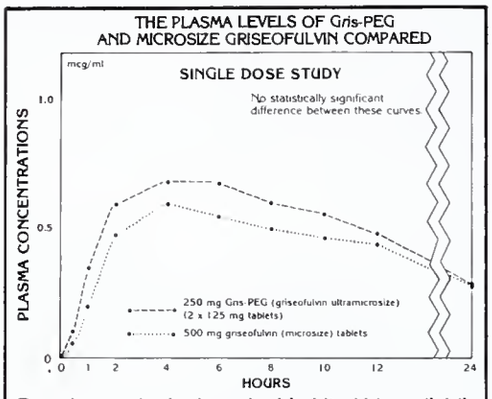
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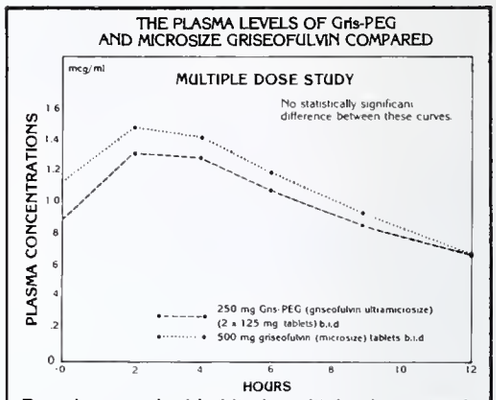
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DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An orel dose of 250 mg of Gris-PEG (griseofulvin ultremicrosize) is biologicelly equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Humen Pharmacofogy).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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obituaries

FRED W. ALEXANDER, M.D., Cleveland; Western Reserve University School of Medicine, 1936; age 65; died November 13; member OSMA and AMA.

DOUGLAS D. BOND, M.D., Cleveland; University of Pennsylvania School of Medicine, 1938; age 65; died November 1; member OSMA and AMA.

JOHN R. BRAUNSTEIN, M.D., Ft. Lauderdale, Florida; University of Cincinnati College of Medicine, 1938; age 71; died November 5; member OSMA and AMA.

JOHN C. DAMITZ, M.D., Akron; University of Iowa College of Medicine, 1933; age 68; died November 9; member OSMA and AMA.

SAAD EL HAWARY, M.D., Coco Beach, Florida; University of Ein Shams Cairo, Egypt, 1964; age 34; died April 1976; member OSMA and AMA.

NORMAN FISHER, M.D., Mentor; Boston University School of Medicine, Boston, Mass., 1948; age 54; died October 25.

BETTY J. FRATIANNE, M.D., Cleveland; Case Western Reserve University School of Medicine, 1953; died October 29.

WILLIAM GOODMAN, M.D., Warren; Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania, 1940; age 63; died November 20.

SOGHIKIAN M. HOREN, M.D., Columbus; Ohio State University College of Medicine, 1928; age 81; died November 5; member OSMA and AMA.

JOSEPH KOSAR, M.D., Columbus; Ohio State University, 1946; age 70; died November 3; member OSMA and AMA.

EDMUND F. LEY, M.D., Tiffin; Loyola University Stritch School of Medicine, Maywood, Illinois, 1933; age 68; died November 1; member OSMA and AMA.

CHARLES D. PADAN, M.D., Ft. Lauderdale, Florida; Ohio State University College of Medicine, 1917; age 82; died October 18; member OSMA and AMA.

HAROLD LEO STELZER, M.D., Lima; Ohio State University College of Medicine, 1923; age 76; died November 10; member OSMA and AMA.

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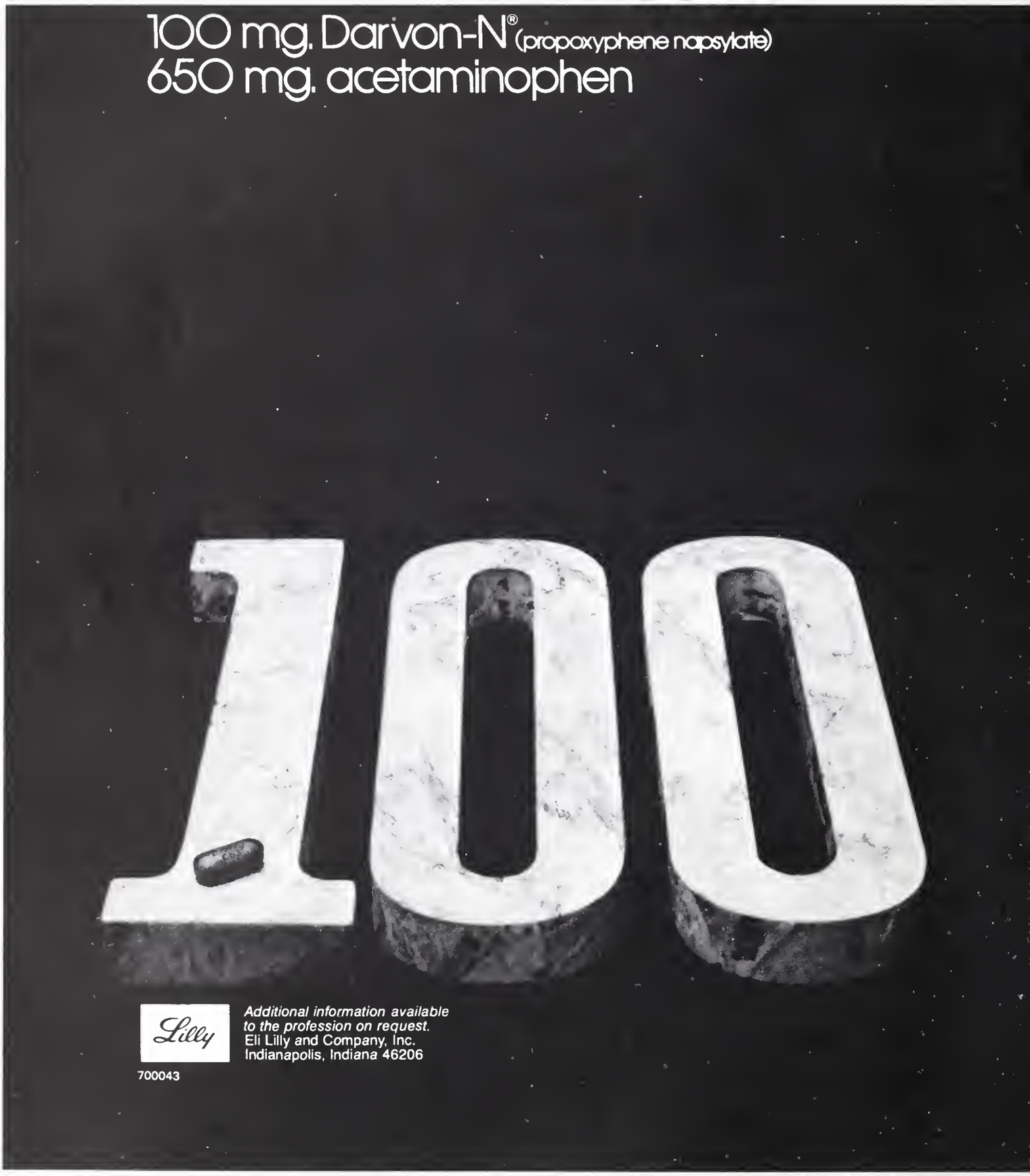
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Clinical and Scientific

Treating Depressed Cardiac Patients

W. Donald Ross, M.D.

Patients with heart disease often are depressed, and yet concern about the toxic effects of antidepressant drugs is justified. Appropriate psychotherapeutic measures are suggested for the mild depression accompanying some common cardiac conditions. In the treatment of more severe depressions, reports of psychopharmacologic studies have been reviewed indicating that doxepin hydrochloride has less cardiotoxicity than other antidepressants.

FAMILY PHYSICIANS AND INTERNISTS have become increasingly cognizant of the frequency of depression in "medical" patients[1,2] and of the possibility of using antidepressant drugs. However, there has been justified concern for risks of precipitating fatal arrhythmia or cardiac arrest by administering tricyclic antidepressants to patients with heart disease.[3-5]

It is important that general physicians and cardiologists recognize that most mildly depressed patients are treatable by psychotherapeutic measures. There is one tricyclic antidepressant drug which can be used cautiously and with relative safety if severe depression is further crippling— or even endangering— the life of a cardiac patient.

Pragmatic Psychophysiology

Two common examples of the aggravation of heart disease by the stress of emotional depression are (1) delayed convalescence after acute myocardial infarction and (2) persistent or recurring congestive heart failure.

The so-called "Type A" personality, who is more prone to coronary artery disease, is inclined to a life style of competitiveness, drive for success, impatience, restlessness, hyperalertness, and a feeling of pressure of responsibilities.[6,7] Such persons have difficulty resting in bed after suffering an infarction. They may respond to the enforced deprivation of motility by denial of illness and rebellion against restrictions, increasing the risk of further damage to the heart. Alternatively, they may become depressed and turn against themselves with pessimism, complain of persistent pain and fatigue, and show reduced effort at increasing activities even though permitted by the physician.

The physician's psychotherapy should consist of explanation and realistically based reassurance to the patient and relatives. After the critical phase has passed, he should encourage gradually increasing activity and responsibility for the patient. These therapeutic attitudes taken by medical and nursing personnel will help to reduce the dangerous denial and to turn depressive aggression outward, toward resuming somewhat-dampened-but-familiar active behavior.

Diazepam or chloradiazepoxide therapy may be used for anxiety and restlessness, but these minor tranquilizers can be conducive to increasing depression if continued for a prolonged period. Only if the postinfarction depression becomes severe should one consider using antidepressant medication, and then only with the precautions presented later.

Emotional stress was first shown to be contributory to congestive heart failure by members of a University of Cincinnati psychosomatic team.[8] Others have since confirmed that a high incidence of personal and social problems is associated with the precipitation of cardiac

(continued on page 22)

From the Adult Psychiatry Consultation-Liaison Service, Cincinnati General Hospital.

Dr. Ross, Cincinnati, Professor of Psychiatry and Associate Professor of Environmental Health, University of Cincinnati College of Medicine.

Submitted August 26, 1976.

failure.[9] The most important psychodynamic principle for the physician to keep in mind, when depression seems to be retarding the response to medical management of the patient with congestive heart failure, is that the patient may have suffered an important loss or a breach in a key relationship.

In taking a history, the physician should be aware of any recent death or separation or any interruption in the continuity of the patient's medical care. Perhaps the patient could be helped (at the physician's suggestion) to work through a grief reaction or to be reunited with a source of support from someone who recently was rejecting or neglectful. The attending physician or resident physician may prevail on a social worker, nurse, attendant, or intern to give the patient regular attention for a long enough time for the patient to re-establish other supportive relationships with family or friends.

That wise clinicians, at the turn of the century and prior to modern cardiology, had some realization of these principles is illustrated by a quotation from an early edition of Osler's *Modern Medicine:* "If cardiovascular diseases do result from nervous influences it is apparent that the physician who learns the mental and nervous habits of his patient is in a position to render great prophylactic service."[10]

Any Antidepressant?

Since some patients with heart disease remain depressed in spite of psychotherapeutic management (with or without psychiatric consultation), and as depression itself may be life-threatening (either by suicide or the aggravation of cardiac disorder), the general physician should be aware of the pharmacologic problems concerning effects of psychotropic drugs on the heart. Most physicians are aware that reserpine, administered for hypertension, may precipitate depression but it may not be as widely known that methyldopa has the same effect at times. Therefore, if a cardiac patient becomes depressed while taking one of these drugs, the physician should discontinue the drug while giving psychotherapeutic support and before prescribing a potent antidepressant.

Thioridazine sometimes is used to treat the depression and anxiety of hypertensive patients since it lowers blood pressure and acts as an antidepressant for some individuals. However, it is a hazardous drug in the presence of hypertensive heart disease since it has been shown to produce electrocardiographic changes similar to those accompanying hypokalemia[11] or quinidine.[12,13]

The use of monoamine oxidase (MAO) inhibitors (isocarboxazid or tranylcypromine sulphate) also is contraindicated in the presence of any heart disease—whether hypertensive or not— because of their toxicity and propensity for producing hypertension, especially if foods containing pressor amines are ingested.[14]

Several of the tricyclic antidepressants have been implicated in sudden death of patients. They have been shown by electrocardiographic studies to exert anticholinergic, adrenolytic, and quinidine-like effects on the heart, manifested by the following sequence after toxic overdosage: sinus tachycardia, conduction defects, supraventricular tachycardia, ST and T wave abnormalities, profound bradycardia, and asystole.[5] In therapeutic doses, they also block the antihypertensive effects of guanethidine.[14,15] Experience with these phenomena have led cardiologists and psychiatrists to avoid using tricyclic antidepressants for depressed cardiac patients.

Electroconvulsive therapy (ECT), which may be lifesaving when there is acute suicidal danger, cannot be used without temerity for patients with heart disease. Drug interactions of the preparatory anesthetics or muscle relaxants may prove fatal or the seizure may precipitate an arrhythmia.[11]

Fortunately, there is a way out of this dilemma. One tricyclic antidepressant, doxepin hydrochloride, with lesser cardiotoxicity can be used safely if started in small doses and with the patient under close observation.

Although a leading clinical psychopharmacologist has expressed skepticism about the antidepressant value of doxepin, pointing out that there are safer anxiolytic agents,[16] several experienced psychiatrists in the United States and Europe have reported effective antidepressant results with doxepin with fewer side effects (especially on the heart and in elderly patients) than for the other tricyclics.[14,17-21]

A team from the departments of pharmacology, psychiatry, and medicine at Vanderbilt University,[15] and another from the cardiac laboratory and department of psychiatry at the University of Melbourne, Australia,[5,13,22] have studied the toxic effects of doxepin in comparison with other tricyclics on hospitalized depressed patients. The latter team also performed acute toxicity studies on guinea pigs.[5]

The Vanderbilt team showed that doxepin produced less increase in the pressor response to norepinephrine than desipramine hydrochloride or protriptyline hydrochloride at comparable doses. Doses of doxepin under 200 mg a day caused no antagonism of the antihypertensive effects of guanethidine which would be demonstrated with other tricyclics at 75 to 100 mg a day, or with doxepin at 300 mg a day.[15]

The Australians found that theapeutic doses of tricyclic antidepressants produced an increase in heart rate (9.1 ± 14.2) and an increase in PR interval on electrocardiography (0.015 ± 0.024), but that the effect on the PR interval was less with doxepin than with nortriplyline although the increase in heart rate was no less with doxepin.[5,13]

They also used His bundle electrocardiography (HBE) for intracardiac conduction studies on patients who had received toxic doses of tricyclics[5,22] and found measurements of the H-V interval to be abnormal in seven of eight patients with overdoses of nortriptyline but normal in six patients with overdoses of doxepin. They have published HBE measurements from one depressed

patient before and during treatment with 200 mg a day of nortriptyline for two weeks, followed by 200 mg a day of doxepin for another two weeks. The A-H and H-V intervals and QRS width were initially at 75 msec, 45 msec, and 80 msec levels. They rose to 120 msec, 80 msec, and 90 msec after two weeks on nortriptyline therapy, but they declined to 78 msec, 50 msec, and 80 msec after two weeks on doxepin therapy.

In their animal studies, the Australians infused 30 guinea pigs with tricyclics at a constant rate (10 mg/kg/min), ten of them with impramine, ten with amitriptyline, and ten with doxepin. Survival times were significantly longer for animals infused with doxepin, averaging over 80 minutes, as compared to about 50 minutes for the guinea pigs infused with the other drugs.

These reports suggest that doxepin can be used with less hazard to the heart than the other tricyclic antidepressants with which it has been compared. There is less evidence that arrhythmias might not be produced by doxepin as by other antidepressants.

Since doxepin also has an antianxiety effect (probably from its sedative action) its use obviates the need for adding a phenothiazine when the patient is suffering from anxiety as well as depression. The combination of amitryptiline hydrochloride and perphenazine, so often prescribed for mixed depression and anxiety, is definitely more dangerous to the heart than a tricyclic antidepressant alone.

Denber et al have reported that even doxepin, 75 mg a day, produces signs of improvement in depression and/or anxiety in 7 to 15 days, as compared to four to nine days for a starting dose of 300 mg a day.[18] They also found no increase in electrocardiographic abnormalities even with the higher doses and suggested that 150 mg a day may be used as a starting dose, increased gradually every three to four days if the depression is not responding.

The most common side effects with doxepin are dry mouth and drowsiness. Because of the sedative effect, the drug often is prescribed in doses of 150 mg in the evening with an additional dose of 50 mg added in the daytime if the depression is not lifting. However, even for non-elderly, depressed, cardiac patients, caution would dictate starting the drug dosages at 50 mg three times a day and monitoring with electrocardiographic tracings before adding larger doses at bedtime if these are needed to relieve depression. The daily dose should not exceed 200 mg if guanethidine is being used to lower blood pressure.[15] For patients over 65 years old, it seems safe and usually effective to start the dosage at 25 mg at bedtime and increase gradually up to 150 mg a day after one week.[19]

Glaucoma and urinary retention are contraindications for doxepin therapy because of the anticholinergic effect which it shares with other tricyclic antidepressants. However, Reid and Blouin have found that these drugs (including doxepin) can be used even with cases of active glaucoma if the patients are followed-up with observation of the pupils, tonometry, mydriatic medication, or surgical correction as needed.[23]

Conclusion

The answer to our question as to whether any antidepressant can be prescribed for severely depressed patients with heart disease is "yes." If it is used with caution, doxepin hydrochloride is an effective antidepressant and antianxiety drug apparently without the hazards of other psychotropic drugs in the presence of cardiac pathophysiology.

Summary

The recognition of the frequency of depression among patients with heart disease is accompanied by concern for risk to the heart from some antidepressant medications.

Psychotherapy can be helpful for patients with mild depressions. Understanding the nature of the personality of patients with two common types of heart disease leads to suggestions for appropriate psychotherapeutic measures that can be initiated by the physician. These measures may be supplemented with minor tranquilizers to reduce anxiety, but most antidepressants are too cardiotoxic to use unless the depression is severe.

More severe depressions require treatment with a relatively safe antidepressant drug. Psychopharmacologic studies have been reviewed which indicate that doxepin hydrochloride has relatively less toxicity for the heart than other antidepressants, and is the drug of choice for severe depression in old people, with or without electrocardiographic changes.

Acknowledgement: The author appreciates the advice and assistance furnished by the following: Charles D. Aring, M.D.; Frank J. Ayd, M.D.; Herman C. B. Denber, M.D., Ph.D.; Pat Enders, M.D.; Gerald H. Gunson, M.D.; Irwin B. Hanson, M.D.; Peter Heiman, M.D.; Stanley M. Kaplan, M.D.; Frederic T. Kapp, M.D.; Thomas A. Vargas, Phar.D.; and Robert Yokel, Ph.D.

Generic and Trade Names of Drugs

Amitriptyline hydrochloride— Elavil (Merck Sharp & Dohme)
Amitriptyline hydrochloride plus perphenazine— Etrafon (Schering), Triavil (Merck Sharp & Dohme)
Chlordiazpoxide hydrochloride— Librium (Roche)
Desipramine hydrochloride— Norpramin (Merrell-National), Pertofrane (USV Pharmaceuticals)
Diazepam— Valium (Roche)
Doxepin hydrochloride— Adapin (Pennwalt), Sinequan (Pfizer)
Guanethidine sulfate— Ismelin (CIBA)
Imipramine hydrochloride— Imavate (Robins), Imipramine HCl tabs (Philips Roxane), Janimine (Abbott), Presamine (USV Pharmaceuticals), SK-Pramine (Smith Kline & French), Tofranil (Geigy)
Isocarboxazid— Marplan (Roche)
Methyldopa— Aldomet (Merck Sharp & Dohme)
Nortriptyline hydrochloride— Aventyl (Lilly)

(continued on page 24)

Protriptyline hydrochloride— Vivactil (Merck Sharp & Dohme)
Reserpine— Serpasil (CIBA)
Tranylcypromine— Parnate (Smith Kline & French)

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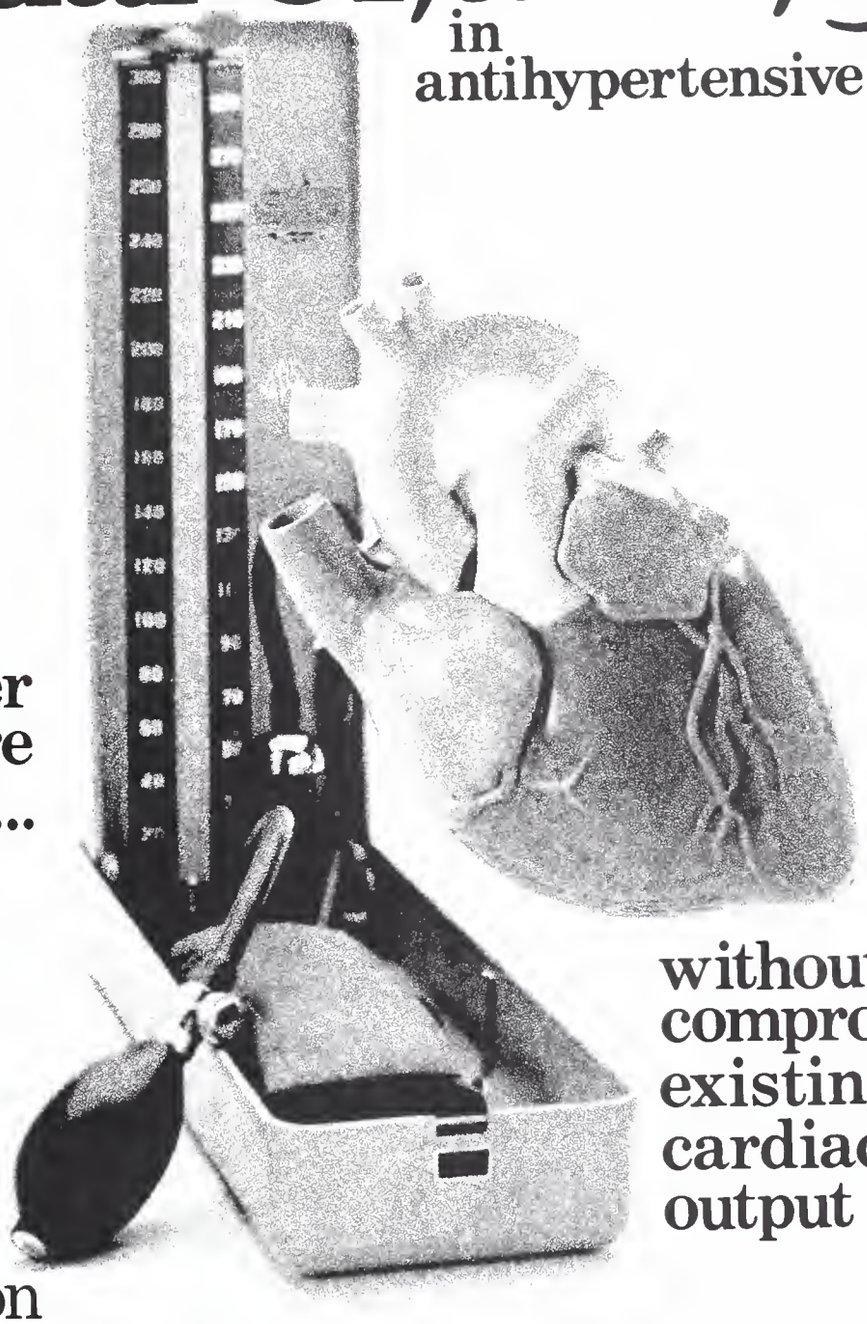
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With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen Reversible thrombocytopenia has occurred rarely When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

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Immunoglobulinopathy in Down's Syndrome

Hammond P. Chen, M.D.
Donald V. Walz, M.D.
Judith A. Carroll, M.T.

The immunoglobulins in 38 institutionalized patients with Down's syndrome, all confirmed by cytogenetic studies, were compared with a control group of other mentally retarded, institutionalized patients. There was no significant increase in IgG globulin, but IgA was increased and IgM was decreased in the patients with Down's syndrome, as compared to the control group. Hepatitis associated antigen (HAA) testing was performed on both groups with 21 percent positive patients in the Down's syndrome group, compared to only 4 percent positive patients in the control institutionalized group. Comparisons of this study with previous work in this field, and the significance of our findings are presented.

THE IMMUNOGLOBULIN CHANGES found in Downs syndrome were regarded generally as being due to infections. There have been several reports of abnormalities in immunoglobulins in patients with sporadic-type Down's syndrome by Pritham et al[1] and Stern and Lewis.[2] In some instances, these results have been inconsistent and contradictory. This study is an attempt to clarify the relationship of immunoglobulins and Down's syndrome. This investigation simultaneously determined serum immunoglobulins IgG, IgA, and IgM, and hepatitis-associated antigen (HAA).

Methods

This study on sporatic-type Down's syndrome reports on 38 patients from the Mount Vernon State Institute in Mount Vernon, Ohio. The patients have the typical facial appearance of Down's syndrome (epicanthal folds, oblique palpebral fissures, broad bridge of the nose, protruding tongue, open mouth, square-shaped ears, and flattened facial profile) and are mentally retarded. All cases have the cytogenetic finding of sporadic-type Down's syndrome, as they are trisomic for chromosome number 21 "G" and have 47 chromosomes.

In these patients, the immunoglobulins were measured by radial immunodiffusion on Hyland Plates.[3] Three standards of high, medium, and low levels were used to plot the standard curve. The results are expressed as milligrams per deciliter (mg/dl). The HAA determinations were made by Ortho's counterelectrophoresis method, including a known positive control.

Fifty-one other mentally deficient patients from the same institution served as the control group.

Results

The data on the random sampling of 38 patients with Down's syndrome is shown in Table 1. The immunoglobulin levels are expressed in mg/dl with mean ± 2 standard deviations in a normal population, the retarded control group, and Down's syndrome. Table 2 shows a 79 percent increase in IgG, a 66 percent increase in IgA, and a decrease of 42 percent in IgM in patients

TABLE 1. Immunoglobulin Levels: Mean ± Standard Deviations in mg/dl

	IgA	IgM	IgG
Normal population	140 ± 60	130 ± 40	950 ± 180
Retarded control group	205 ± 88	158 ± 105	1275 ± 251
Down's syndrome	319 ± 84	65 ± 15	1578 ± 411

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Submitted August 9, 1976.

with Down's syndrome, using the normal population level for comparison. However, when the Down's syndrome group is compared to the institutionalized control group, variations are less apparent. When the mean ± 2 standard deviations of both populations are determined for IgG, IgA, and IgM, the Down's syndrome group revealed no increase in IgG, but there was a 37 percent increase in IgA and a 24 percent decrease in IgM.

Studies with HAA determinations are presented in Table 3. The Down's syndrome patients had 21 percent positive findings, and the retarded control group had only 4 percent positive findings. This certainly is in disagreement with the other reported investigations, as Sutnick et al found a much higher incidence of positive HAA in Down's syndrome patients.[4]

Discussion

Esber et al[5] found that all patients with Down's syndrome, irrespective of age or sex, had marked increase in IgG, but they found only slight increase in IgA and no change in IgM. They reported 65 percent of patients with Down's syndrome had positive HAA tests. Their conclusion was that the elevation of the IgG suggested a chronic response to an infectious agent and was not an immunologic malformation in Down's syndrome patients.

In a direct comparison of patients with Down's syndrome with other mentally retarded and normal children, it was found that IgG increased and IgM decreased in Down's syndrome.[6] It was postulated that the immunoglobulin alterations were not peculiar to Down's anomaly but were related to other disorders of the reticuloendothelial system.

Griffiths et al[7,8] could not confirm these findings, but found an elevated IgA in male patients with Down's syndrome and felt that the increase in IgA correlated with the frequency of infections in patients with Down's syndrome. There are various conflicting reports of the immunoglobulin levels in patients with Down's syndrome. Apparently all authors found elevation in the IgG, but there was a difference in reports of IgA and IgM, the levels being either elevated or normal.[9,10]

Stewart et al[11] and Ruvalcaba and Thuline[12] reported separately an absence of immunoglobulin IgA in patients with a chromosome 18 trisomy. Elves and Israëls[13] reported three cases with abnormal, large chromosomes associated with macroglobulinemia. These authors suggested that a relationship existed between the lymphocytes, the cell that was cultured to determine the chromosome pattern, and protein synthesis. They suggested two possibilities for the relationship between a genetic defect and protein abnormality. Either the abnormal chromosome and abnormal protein production are unrelated or the abnormal chromosome confers upon the cells the ability to produce abnormal immunogammaglobulin under certain conditions. They felt that the stimulus producing the dysproteinemia was antigenetic.[14-16]

Our findings do not establish chronic infection as an etiology for the altered immunoglobulin. In contrast to previous work on Down's syndrome, in which approximately 30 to 65 percent of the patients were found to have positive HAA, our sampling revealed 21 percent of the patients with Down's syndrome to have positive HAA. The control group from the same institution had only 4 percent positive for HAA. This is a fivefold increase in the frequency of HAA in the Down's group.

It would seem to indicate that the immunoglobulin abnormality in the patients with Down's syndrome is not related to infection, poor hygiene, or other environmental conditions, but suggests that the immunoglobulin abnormality is of a basic genetic nature. We suggest that abnormalities in immunoglobulins seen in patients with Down's syndrome are a basic congenital defect and represent another stigma of Down's syndrome. We propose that the immunoglobulin abnormality in Down's syndrome is a biosynthesis defect in origin and is related to the abnormal chromosome.

TABLE 2. Comparison of Immunoglobulins of 38 Down's Syndrome Patients

Immunoglobulin	No. Down's Abnormal	Percentage
IgA	25 ↑	66 ↑
IgM	6 ↓	42 ↓
IgG	30 ↑	79 ↑
Comparison of Down's Syndrome to Retarded Control Group Levels		
IgA	14 ↑	27 ↑
IgM	9 ↓	24 ↓
IgG	0	0

TABLE 3. Comparison of HAA in Down's Syndrome Patients and Retarded Control Group

	Down's Group	Retarded Control Group
Patients tested	38	51
HAA positives	8	2
HAA positives (%)	21	4

Acknowledgment: Kathleen G. Purdy, M.T., assisted in this study.

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Use of Metolazone in the Treatment of Refractory Hypertension

Eugene R. Benedetto, M.D.

Twenty-nine hypertensive patients with a history of side effects and inadequate response to various antihypertensive therapy were given metolazone, 5 or 10 mg per day, for periods up to three months. Thirteen of the patients received metolazone alone, while the remaining patients received metolazone as concomitant medication with other antihypertensive or diuretic agents such as hydrochlorothiazide or furosemide.

During the course of therapy with metolazone, mean blood pressure declined in 22 of the 29 patients, from a mean of 169/93 mm Hg initially to 155/88 mm Hg at the time of this review. Only five patients complained of side effects while on the metolazone therapy.

SEVERAL INVESTIGATORS have recently reported successful treatment of hypertension with metolazone,* a new quinazoline derivative that also has been shown to be of value in the treatment of edema due to renal disease.[1-3] A sulfonamide diuretic, metolazone ($C_{16}H_{16}ClN_3O_3S$), appears to exert its primary action in the cortical-diluting segment of the nephron, but it also blocks reabsorption in the proximal tubule to some extent.[4,5]

In a double-blind study of 57 nonedematous, hypertensive patients, three doses (1.0, 2.5, and 5.0 mg) of metolazone proved as effective as chlorthalidone, 100 mg daily. Approximately the same incidence of potassium lowering incurred with both drugs.[6] Two cross-over comparisons with hydrochlorothiazide have been published. Pilewski et at[7] reported metolazone (2.5 or 5.0 mg) to be as effective in lowering the blood pressure of 21 hypertensive patients as was hydrochlorothiazide, 50 mg. More recently, Sambhi et al[8] have reported that a single daily dose of 5 mg of metolazone provided significantly superior control of the blood pressure of 33 males with essential hypertension than was provided by hydrochlorothiazide, 50 mg, administered twice a day.

The study of prolonged administration of metolazone carried out by Cangiano et al[9] did not reveal any problems of developing tolerance to the drug or an increase of side effects after up to 92 weeks of therapy. These investigators concluded that the characteristics they ascribed to metolazone, its "high frequency of *good-to-excellent* response, once-a-day administration, potentiation of other nondiuretic antihypertensive agents, and the failure of tolerance to develop in 'long-term use' were its apparent major advantages."

We have recently begun to use metolazone in selected hypertensive patients. This article reports the results of our initial experience.

Patients and Methods

With an established four weeks of therapy as a minimum for evaluating response, we reviewed our patient records and identified 26 patients who had received metolazone for at least that long. Three other patients who had been treated for only two weeks were included because they reported symptoms that could have been related to drug administration. The mean duration of metolazone therapy in this group of 29 patients was 7.1 weeks, but three patients had received the drug for more than three months up to the point at which this review was undertaken.

Demographic characteristics of the 21 females and eight males are shown in the Table. Obesity was clearly a substantial problem in this population, particularly among the female patients, whose average weight was 86.8 kg (191 lb). Five female patients weighed more than 99.8 kg (220 lb). The most commonly associated medical problems were coronary artery disease and general arteriosclerosis. Seven of the patients were diabetic, and a similar number had advanced rheumatoid arthritis. Phlebitis was a problem with several patients.

Metolazone had been prescribed for these patients because adequate control had not been achieved or maintained with other antihypertensive agents. Thus, the population was a highly selective one, consisting of cases

*Produced under the name Zaroxolyn® by Pharmaceutical Division, Pennwalt Corporation, Rochester, N.Y.

Dr. Benedetto, Alliance, Attending Staff, Alliance City Hospital.

Submitted August 25, 1976.

Demographic Characteristics of 29 Patients on Metolazone Therapy

Sex	No. of Patients	Age (Years) Range	Age (Years) Mean	Weight (kg) Range	Weight (kg) Mean
Male	8	27-75	53.1	66.2- 91.3	90.2
Female	21	27-79	59.3	54.9-119.8	86.7
Both	29	27-79	57.6	54.9-119.8	84.9

of intractable hypertension and those in which complaints of side effects had limited previous therapy. The systolic pressure of the majority of these patients before treatment with any antihypertensive agent had been equal to or greater than 190 mm Hg. Because of previous therapy, however, mean blood pressure at the start of metolazone therapy was 168.9/93.0 mm Hg.

We initially began metolazone administration with single daily doses of 5 mg, but several patients seemed to respond better to double that amount. Thus, we eventually began to use the higher dosage at the start of therapy. Ten of the subjects of this review were started on metolazone, 10 mg/day, and four more were switched to 10 mg/day after beginning with 5 mg. About half of the patients, therefore, received the higher dosage.

Sixteen of the patients first received metolazone as concomitant therapy with another antihypertensive agent or diuretic— most often hydrochlorothiazide, but furosemide and polythiazide were employed as well. In three cases, both hydrochlorothiazide and furosemide were coadministered with metolazone.

Since this was our first trial of metolazone, special attention was given to any patient complaints that were considered to be possible drug reactions, and patients were readily switched to other therapy if they expressed any reservations about the new treatment.

Results

Blood Pressure.— Given the nature of our patient population, the rapidity and magnitude of the response to metolazone both were judged to be very satisfactory. Mean blood pressure dropped from 168.9/93.0 mm Hg when metolazone therapy was initiated to 155.3/88.1 mm Hg at the most recent observation. A more revealing perspective may be provided by the numbers of patients experiencing adequate control before and after metolazone treatment. At the start of metolazone therapy, no patient had a blood pressure equal to or lower than 140/90 mm Hg, and only three had a pressure equal to or less than 150/90 mm Hg. At the most recent measurement, eight patients had pressures of $\leq$140/90 mm Hg and another four had pressures of $\leq$150/90 mm Hg.

Either systolic pressure, diastolic pressure, or both declined in 22 of the patients. Blood pressure remained essentially unchanged in four patients, and three experienced an increase while receiving metolazone. Three of the four patients whose blood pressure remained unchanged and one of those whose pressure rose were receiving 5 mg of metolazone alone, that is, with no other antihypertensive medication. However, all of the other nine patients who received metolazone alone responded well; their mean blood pressure of 161.9/90.4 mm Hg at the start of the metolazone therapy declined to 151.4/86.1 mm Hg at the most recent measurement. Seven of these nine were receiving daily doses of 5 mg. Patients who failed to respond to metolazone alone or complained of possible side effects (see Adverse Reactions) were switched to either polythiazide or a combination of reserpine, hydrochlorothiazide, and hydralazine.

Adverse Reactions.— Six patients reported effects that were judged discomfiting enough to warrant discontinuance of the metolazone therapy, although it was not certain that all the complaints were, in fact, drug reactions. A 59-year-old housewife weighing 102 kg (225 lb) experienced chills two weeks after treatment with metolazone, 5 mg/day, was introduced. A 46-year-old housewife suffering from phlebitis and weighing 118.5 kg (261 lb) reported palpitations shortly after her dosage of metolazone had been increased from 5 mg to 10 mg per day. She also was receiving furosemide, 40 mg per day. A 57-year-old woman weighing 87.6 kg (193 lb) complained of nausea and fatigue. Her daily regimen consisted of metolazone, 5 mg, hydrochlorothiazide, 25 mg, and furosemide, 40 mg. A 50-year-old man reported vertigo the same day he began metolazone therapy. A 52-year-old woman, who was also receiving both hydrochlorothiazide and furosemide, was taken off metolazone therapy after two weeks because of nausea comparable to that of which she had complained previously while receiving polythiazide.

Finally, metolazone was discontinued in the case of the sixth patient because her blood pressure had declined from 168/92 to 118/60 mm Hg in only two weeks. She weighed 124.4 kg (274 lb) and also was receiving hydrochlorothiazide, 25 mg, and furosemide, 40 mg, each day, in addition to metolazone, 5 mg.

Only two of these six patients were receiving more than 5 mg of metolazone per day; however, all but two were receiving other antihypertensive medications as well. All three patients who received metolazone together with both hydrochlorothiazide and furosemide reported side effects, although use of either of these agents alone with metolazone presented no problem of consequence.

Discussion

Published studies of metolazone have been very favorable generally with respect to its relative low incidence of side effects.[1,8,9] We considered the frequency of complaints low in this study as well, considering the nature of the population. All of these patients had been treated previously for hypertension; many had received several drugs and had come to "expect" side effects from such therapy. Side effects in this study were of the type often encountered with the thiazide diuretics. As with

thiazides, potassium lowering also has been reported to occur with prolonged administration of metolazone, but the present review probably covered too short a period of time to permit an adequate evaluation of changes in electrolytes. Nor were pretherapy potassium levels available for the few patients who had relatively low potassium levels during treatment with metolazone. None of these patients, however, experienced symptoms typical of hypokalemia.

In this series, patients experiencing reactions tended to be those who were more obese and those who were receiving multiple diuretics concomitantly. All three patients who were given metolazone together with furosemide and hydrochlorothiazide reported adverse reactions although, when either was administered alone with metolazone, each combination was both well tolerated and effective.

For example, when a 59-year-old housewife with coronary artery disease received metolazone, 5 mg, in addition to her established regimen of hydrochlorothiazide, 25 mg per day, her blood pressure dropped from 180/95 mm Hg to 152/90 mm Hg with no report of unpleasant reactions. This patient subsequently was discovered to have asymptomatic hypokalemia, but her potassium level responded quickly to supplementation.

A 55-year-old woman had suffered from hypertension for five years and had received polythiazide as well as a combination of guanethidine with hydrochlorothiazide. In addition to hypertension, she suffered from diabetes, hypothyroidism, and anemia. After initiation of a regimen of metolazone, 5 mg, plus furosemide, 40 mg per day, her blood pressure declined from 199/106 mm Hg to 160/90 mm Hg at the end of two months. After five months of therapy, her blood pressure remained well controlled at 150/92 mm Hg, and there were no signs of intolerance. One patient, however, did experience palpitations while receiving furosemide together with metolazone.

The results of concomitant administration of metolazone and polythiazide are less clear. Only two patients received this combination. One had an initial blood pressure of 160/70 mm Hg. At the last measurement, after some ten weeks of therapy, his blood pressure stood at 142/80 mm Hg. The other patient, a 89-kg (196-lb) woman with diabetes, coronary artery disease, and arthritis, experienced a slow-but-steady rise in blood pressure from 160/80 mm Hg at the start of therapy with polythiazide, 2 mg, and metolazone, 10 mg, to 178/96 mm Hg after five weeks of therapy with these drugs.

It has been reported that metolazone can enhance the effects of methyldopa, reserpine, and hydralazine.[9] Our experience with these combinations has been limited, but based on the present series of patients, we may say that metolazone appears to be a safe and effective antihypertensive drug when given alone or coadministered with hydrochlorothiazide or furosemide.

Summary

This initial trial of metolazone with patients who had failed to respond to other antihypertensive agents suggests that metolazone is an effective drug, often able to provide satisfactory control in patients who failed to respond to previous therapy. It works well alone or concomitantly with furosemide or hydrochlorothiazide, but use of the three agents together may lead to a higher frequency of adverse reactions. Further studies of its use with other antihypertensive agents should be undertaken.

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Clinical & Scientific Specialty Series

Physical Medicine and Rehabilitation

Ernest W. Johnson, M.D.

(**Editor's Note:** As continuing medical education has been and is becoming more of an important aspect of the medical profession, *The Journal* is initiating a new clinical and scientific series. The editorial staff has requested authorities in various medical specialties to present articles communicating recent developments and/or areas requiring emphasis in their fields. We hope that each OSMA member can gain a review of the specialties through these articles.—R.L.M.)

SEVERAL THOUSAND YEARS elapsed from the time the cave man backed up to the fire to soothe his bruised bottom to the application of ultrasound to the joint sprain. Physical treatment of disease and injury is appropriate, specific, and generally without side effects. The application of such techniques for the mitigation of residuals of disease or injury is a part of the specialty of physical medicine and rehabilitation. Physical medicine became a specialty in 1947, and the concept of rehabilitation was added in 1948. The discipline of rehabilitation medicine, as it has come to be called, represents the development of compensatory mechanisms for the disabilities imposed by disease or injury.

The late Frank Krusen, M.D.,* generally considered the father of physical medicine, would define physical medicine as the diagnosis and treatment of disease with the use of physical agents, ie, heat, light, electricity, physical principles, and other agents.

Electrodiagnosis and electromyography have come to be an important part of the diagnosis of neuromuscular diseases and represent a substantial portion of the practice of physical medicine and rehabilitation. This comprises the investigation of the electrical activity associated with muscle contraction as well as the measurement of motor and sensory nerve conduction velocity.

Many physicians are uninformed about the value of and procedures involved in these electrodiagnostic studies. They are unique in medical diagnostic techniques, as an extension of the history and physical examination of the patient. As the findings unfold, the planned procedure is modified to come to a clinical decision about the probable diagnosis and prognosis. Electromyography and nerve conduction studies are helpful in the management of rachiopathies, nerve injuries, neuromuscular conditions including those affecting the anterior brain cell, axion, myoneural junction, and muscle fiber.

Howard Rusk, M.D.,* who is generally considered the father of rehabilitation medicine, would define rehabilitation as the third phase of medicine, the first phase being preventive and the second being acute disorders.

Chronic disease is of such consequence in this country that a majority of the practice of most physicians is involved with the management of chronic conditions. One might consider that being alive is a progressive disease, and for this reason, the application of techniques for removing functional impairment, minimizing disabilities, and promoting the maximum restoration of function are relevant to almost all of medicine.

The Role of Rehabilitation Medicine

Generally, the specialty of rehabilitation medicine concerns itself with conditions affecting mobility or function. The late statesman, Bernard Baruch, once defined rehabilitation as the conservation, cultivation, and preservation of human resources. While this seems to be a somewhat broad definition, the concept of maximizing the residual function of a disabled person seems to be a more satisfactory way of approaching the field.

Some of the residuals which result in disability include pain and motor dysfunction, ie, weakness, spasticity, incoordination; joint limitation; sensory deficits; and absence of a limb or a portion thereof. These residuals of disease or injury impose certain functional restrictions on a patient. His disability may be further compounded by his educational deficiencies, concern for his job, his family, his self image and concept, and many other problems. This makes the task of rehabilitation much more complex

*Professor Emeritus, Department of Physical Medicine and Rehabilitation, Mayo Foundation; former Chairman, The Baruch Commission on War and Postwar Physical Medicine and Rehabilitation; recipient of AMA Distinguished Service Award in 1956.

*Professor Emeritus, Department of Rehabilitation and Physical Medicine, New York University School of Medicine; Associate Editor of *The New York Times;* Consultant in Rehabilitation and Physical Medicine to the Secretariat of the United Nations and to the Baruch Commission on War and Postwar Physical Medicine and Rehabilitation.

Dr. Johnson, Columbus, Chairman, Department of Physical Medicine, The Ohio State University College of Medicine.

Submitted November 9, 1976.

and involves many other health professions — the rehabilitation nurse, physical therapist, occupational therapist, speech therapist, psychologist, social worker, teacher.

A severely disabled individual may present so many problems that the rehabilitation team, headed by the physician, must establish a series of priorities. These are based on certain objectives that are generally accepted as applicable to most disabilities. These include (1) communication; (2) activities of daily living — the things all of us take for granted — grooming, eating, dressing, toileting; (3) improving upper extremity function; (4) ambulation — may not include walking per se but simply a means of getting around. (The metabolic cost of walking with braces and crutches may be so excessive as to prevent functional walking.); (5) vocation for adults and education for children; (6) normalcy; and (7) avocation or diversion.

These seven objectives act as a template for the rehabilitation process. Oftentimes, the patient will have different priorities than the physician, but these can be worked out during the actual rehabilitation effort.

Training Programs

The training of physicians specializing in physical medicine and rehabilitation in this country includes opportunities at over 60 medical schools. The American Board of Physical Medicine and Rehabilitation requirements are three years of residency training and one year of practice for certification. This physician-specialist is termed a physiatrist. (Accent is on the third syllable, according to Dr. Krusen who coined the term.) In a recent inventory of graduates from the medical schools in this country, conducted by the American Medical Association, it was determined that The Ohio State University College of Medicine (OSU) contributed more of its graduates to the specialty of physical medicine and rehabilitation than any other medical school. The OSU postgraduate training program for this specialty also is one of the largest and is quite well known.

Physical Agents

The Bureau of Vocational Rehabilitation (BVR) is a state/federal agency with the primary objective of restoring disabled individuals to compensable employment. This agency encourages referrals from all physicians to provide these opportunities for their injured and disabled patients. (See the Table.)

While it is certainly one of the oldest medical techniques, the use of physical agents in the diagnosis of disease and injury is still extremely useful; it probably is among the most rational since the treatment is directed very specifically to the injured area.

The approach a physiatrist will use is to evaluate the patient for his residual function and to then develop treatment strategies to compensate for the lost abilities. These strategies may include the elimination of the disabling condition, if possible; the mitigation of the physiologic impairment or, when it cannot be removed or lessened, then the development of certain compensatory mechanisms that will allow the individual to function as normally as possible within the limitation of his disability.

The many other rehabilitation professionals involved are necessary since the psyche and the soma cannot be separated, and everything that affects the body, therefore, must have a psychologic effect. The family constellation, the job, and the patient's concept of himself are all intimately involved with his rehabilitation.

Conclusion

It is estimated that there are about 1,500 specialists in the field of physical medicine and rehabilitation in the United States; there is an immediate need for more than double this number. Senator Edward M. Kennedy (Democrat-Mass.)* recently indicated that rehabilitation medicine should be considered a scarce specialty, right along with primary care. Rehabilitation medicine is a very satisfying medical specialty since contacts with the patient extend over long periods of time and afford the opportunity for developing a meaningful relationship between the physician and the patient.

There are many humanitarian reasons for rehabilitating diseased and injured individuals, but the economics of the situation make it a necessity in our society today.

*Chairman, Subcommittee on Health

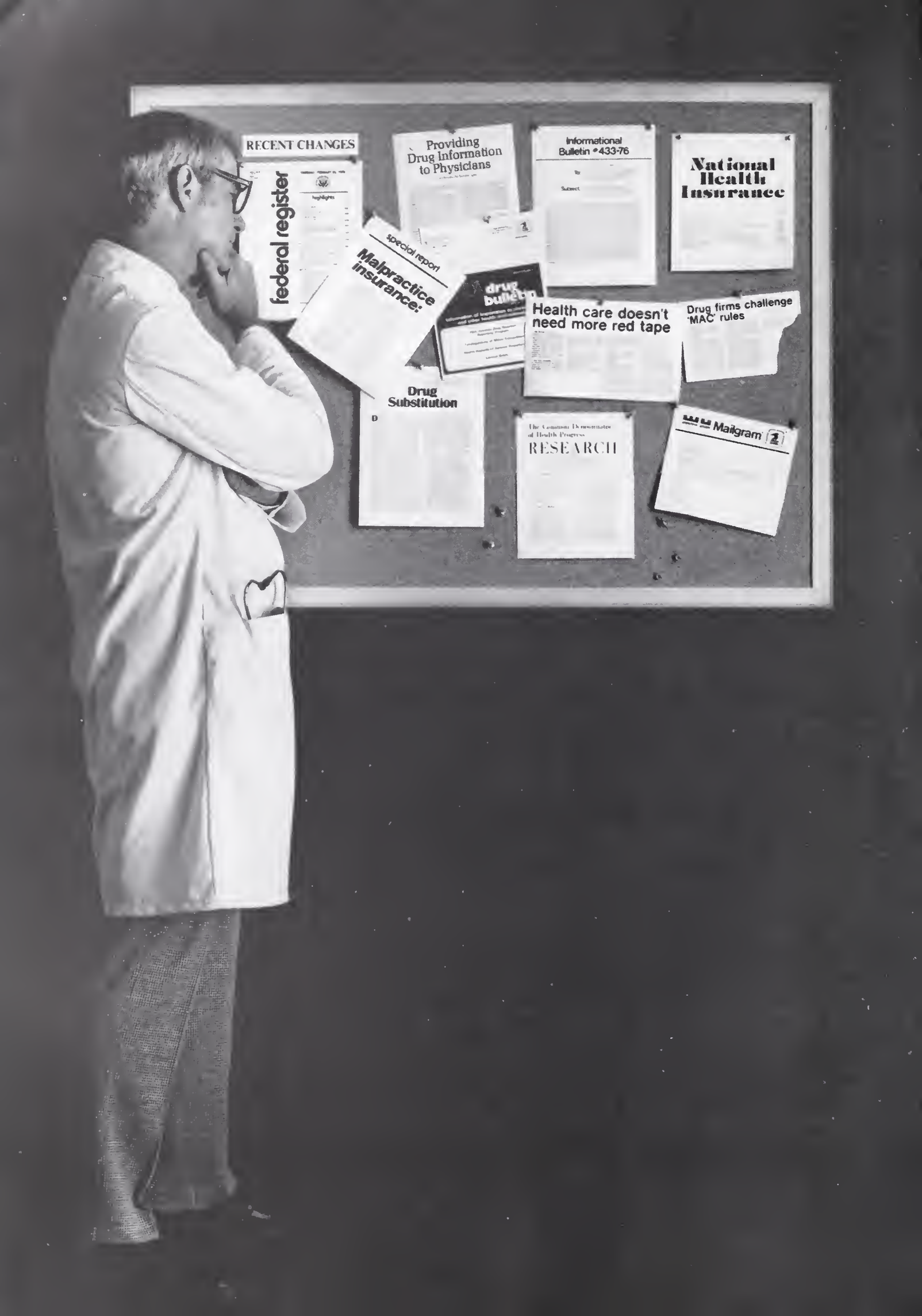
Referrals to Bureau of Vocational Rehabilitation

No matter what the patient's physical or mental disability may be, if it interferes with his/her getting or returning to a job, the Ohio Rehabilitation Services Commission (RSC) can help through its Bureau of Services for the Blind (BSB) for visual impairments, or Bureau of Vocational Rehabilitation (BVR) for all other physical and mental handicaps.

Physicians can simply call or write their local BSB or BVR office, giving the patient's name, address, phone number, and disability. A rehabilitation counselor will then contact that patient, at home or while he's still in the hospital, to discuss potential rehabilitation services and his vocational interests.

Pamphlets also are available from RSC which can be supplied to physicians for their patients. Those patients motivated enough to do so then could contact the local rehabilitation office themselves.

Information is available from local BSB or BVR offices or from Virginia Stull, M.D., RSC Administrative Medical Consultant, 4656 Heaton Road, Columbus, Ohio 43229, or the Division of Information, at that same address.


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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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news

Medical Board Activity

The following is a list of activities and actions undertaken from November 1, 1976 to November 30, 1976, by the Ohio State Medical Board.

LICENSURE ACTIVITY

Am. Medical School Graduate Endorsements	M.D.	45
	D.O.	10
Foreign Medical School Graduate Endorsements		7
Sept. 1972 FLEX Board Policy Licenses	M.D.	4
	D.O.	0
Endorsements to Other States	M.D.	37
	D.O.	2

ENFORCEMENT ACTIVITY

Formal Citations Issued	2
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	9
Voluntary Surrenders of Medical Certificates	1
Arrests for Alleged Illegal Practice of Medicine	2
Formal Hearings on Alleged Violations of the Medical Practice Act	4

Columbus Bank Participates In AMA-ERF Loan Program

City National Bank and Trust Company of Columbus is one of nine banks currently participating in the American Medical Association Education and Research Foundation's guaranteed loan program. This program, which began in 1962, offers financial assistance to medical students.

Record Medical School Enrollment

57,236 medical students, a total that includes 15,349 first-year students, were enrolled in the nation's 116 medical schools this fall, according to a survey conducted jointly by the AMA and the Association of American Medical Colleges. The total enrollment— a record number— represents a 29 percent increase from five years ago and is about 9.7 percent greater than last year's total. First-year enrollments this fall were 24 percent greater than the figure of five years ago and about 9.4 percent greater than last year. Women and minority student enrollments are about the same as last year. Women students represent 20.4 percent of total enrollment this year, while minority students made up 8.2 percent of total enrollment and 9.3 percent of the freshman class.



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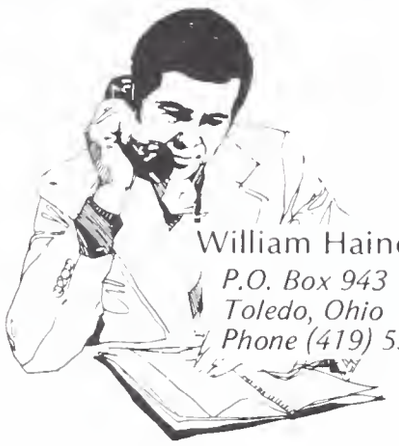
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ohio medical school highlights

Curriculum Innovations At Case Western Reserve University School of Medicine

Frederick Robbins, M.D., Dean

Back in the 1950s, Western Reserve School of Medicine embarked on some experiments in medical education which attracted considerable attention at the time, many of which have since been adopted or adapted by other medical schools in this country and abroad. In essence, the 1952 Reserve curriculum, with a built-in flexibility to adapt to changing priorities, sought to present medicine as a whole concept rather than as a series of unrelated disciplines, and to treat the student as a mature individual who would take the initiative in the learning process.

A major innovation, with which our faculty was concerned 25 years ago and which is still an important component of our curriculum, was the introduction of clinical contact for students from the beginning of the first year of their medical studies. This was, and is, done to encourage the positive attitudes with which most students enter medical school; to develop in them proper professional attitudes by enabling them to attain a degree of self-awareness and an understanding of the special relationship between doctor and patient; to give them exposure to clinical teachers who might serve as models for their own career development; and to begin to teach how to collect, record, and communicate clinical data. In recent years, with increasing emphasis on the concept of primary care, the role of the Phase I student-doctor is seen as approaching that of the primary care practitioner; this is a field which almost half of our Case Western Reserve graduates enter.

The Clinical Science programs of Phase I and Phase II occupy a day a week in the essentially basic-science years; the third year involves total immersion in hospitals in five basic clerkships; the fourth year consists completely of clinical options except for a required two-month clerkship in Ambulatory Medicine. Because the Phase I experience typifies so much of the Reserve philosophy it is described here in some detail.

The program consists of five parts:

Involvement of the student in the health care of a patient and his/her family

A "whole class exercise," usually a lecture, once a week

Small group discussions (preceptor groups)

Interviews of programmed patients in a video-taped playback session

A trip with a visiting nurse to visit a patient in his/her home

Most of the class has an obstetric-pediatric experience involving a student in the health care of a pregnant woman and then her new-born infant, either under the direction of a family practitioner or specialists in obstetrics and pediatrics. A small group of M.D.-Ph.D. students have an experience in adult medicine.

In all of these programs, students make home visits to get to know the other members of the family, to see the patient in a situation in which he/she is more comfortable than in a clinic, to observe the effect of environmental factors on the health and development of the patient, and to indicate concern and interest in the patient and his/her family. The trip with the visiting nurse introduces the student to the role of community agencies in health care.

With these "patients," the student, under supervision, is providing primary care for the first time; he is working in a hospital, wearing a scrub suit, seeing a baby born, listening to heartbeats. He is the individual who is concerned with the patient as a person, who provides the continuity, who acts as liaison between the patient and the medical profession, making sure that questions and concerns are heard and dealt with.

The whole class exercise is devoted to a general topic; and the programming is very responsive to student input, as an outgrowth of their expressed needs to participate in their own education. The lecture may be devoted to such questions as the economics of medical care, psychological problems of pregnancy, the sociology of the ghetto black, and how to take a sexual history.

In the group discussions which follow, ten students led by two preceptors (a physician and a social worker), either exchange ideas on the lecture subject or discuss their clinic patients. Here they can learn much from each other, for our students come from very diverse backgrounds and bring rich experiences to the medical school; some are Ph.D.'s in psychology, or theology, or sociology, some have been involved in various areas of health care between college and medical school. Here also they become aware of their own predispositions, expectations, competencies and "hang-ups." As a part of their personal development, they often learn a different view of the lecture and exchange experiences with other students.

(continued on page 42)

Medical School Highlights *(continued)*

Additional clinical exposure in Phase I is provided by a series of exercises to correlate basic science materials with relevant aspects of clinical medicine. These small-group activities usually involve a trip to an area hospital, exposure to a medical specialist, and interviews with patients, covering such subjects as diabetes, alcoholism, birth defects, coronary care, and renal dialysis units. Free-day activities are planned by individual preceptor groups and include field trips to such locations as burn units, methadone clinics, mental health centers, special hospitals for abused children, and the county jail.

We are concerned with helping our students in the process of developing professional behavior, to convert and alter those social skills which they bring to medical school into a professional context. In acquiring the ability to interview patients, students are taught that the way they say things, the way they look, their tone of voice, and the way they feel at the time can, and do, make a difference in the patient's care.

A recent innovation in the several ways in which we introduce our students to the human side of medicine is a video-taped interview of a simulated patient, which is observed on a monitor and later criticized by a faculty or staff member and a fellow student in a playback session. The "patients" are individuals who are programmed ahead of time to present with problems of diabetes or pregnancy; they do not follow a tight script, but are encouraged to use their own ingenuity in responding to whatever questions the students pose. It's a fresh experience as student and patient have never met before; and each student conducts at least two interviews and observes a fellow student twice.

The playbacks are an excellent means of self-evaluation; the student looks hard at himself in what may be a satisfying or a humbling experience, but never a boring one. Students are keenly involved, in both interviewing and observing and evaluating their fellow students in a form of peer review.



Case Western Reserve medical students discuss the playback of the simulated patient interview with a faculty member.

In most of the activities in Phase I Clinical Science, students are enthusiastic participants in the learning process. This helps them to develop professionally in the best sense of the word, eventually able to go into the hospital and clinics with a kind of maturity and comfort that was not always present in our generation. This comfort and maturity allows for greater expression of their compassion, empathy, and humanism and results in better patient care.

Editor's Note: This article marks the first of a bimonthly series of articles written by the deans of Ohio's medicals schools. These articles will cover topics about the individual schools of interest to OSMA members. Issues of *The Journal* not containing this series will offer medical school news from all campuses.

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proceedings of the council

November 6-7, 1976

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 6, and Sunday, November 7, 1976, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Dr. J. Hutchison Williams); Dr. P. John Robechek, Cleveland, Chairman, Ohio Delegation to the AMA; Dr. John H. Budd, Cleveland, President-Elect of the AMA; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Messrs. Joseph K. Gilmore, Columbus, President, and David L. Rader, Columbus, Vice President-Administration, The Physicians Insurance Company of Ohio; Dr. James L. Henry, Grove City, Vice President and Medical Director, Medical Advances Institute; Mr. Edward A. Lentz, Columbus, President, Medical Advances Institute; Mr. Alfred F. Hartmann, Columbus, Director of Administrative Services, Medical Advances Institute; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Houser, Mulgrew, Holcomb, Freeman, Ayish, Mrs. Wisse, Mrs. Dodson and Mrs. Jacobson, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Dr. Maurice F. Lieber and Dr. Williams); Mr. Pohlman; Mrs. Joy Myers, Circleville, President of the Ohio State Medical Association Auxiliary; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Houser, Mulgrew, Holcomb, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

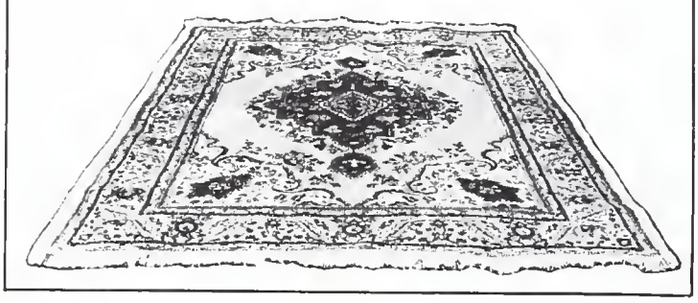
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MINUTES

The minutes of the September 25-26, 1976 meeting were amended in paragraph 4, page 82 of the official minutes to read as follows:

MEDICAL SERVICES REVIEW PROCEDURES

OSMA procedures for Medical Services Review were reviewed and discussed and it was the Council's decision to continue for the time being the present review policies and procedures. Staff and Legal Counsel were directed to continue monitoring the situation and to report at future meetings any developments which might be relevant to a reconsideration of the current review policies and procedures.

The minutes were **approved** as amended.

The minutes of the meeting of Council on October 22, 1976, held by conference telephone call **were approved.**

MEMBERSHIP

Membership statistics were presented by Mr. Page. OSMA membership as of October 31, 1976, was 126 ahead of the same date in 1975, while AMA membership was less by 425 members.

Dr. Budd discussed proposals which are slated for consideration at the December meeting of the AMA House of Delegates having to do with increasing the effectiveness of the American Medical Association membership program. Alternatives to be considered include:

1. Direct billing of physicians by the American Medical Association for the AMA portion of physicians' dues. Before final processing of the individual physician's membership, the AMA, under this system, would determine eligibility for AMA membership by cross-checking to assure that membership in the state and county medical societies is current.

2. A total unified system wherein the state medical associations would be members of the AMA Federation and be responsible for tendering the AMA portion of the physicians' dues to the American Medical Association on behalf of all state association members.

3. Direct AMA membership.

The Council discussed a possible alternative which would permit the American Medical Association under concept number one, to bill direct for AMA members in the smaller counties, but to continue billing by the state or county medical societies if they are equipped to do so.

(continued on page 46)

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proceedings of the council

(continued from page 44)

The Council also reaffirmed its strong support of the federation concept.

A motion in support of qualifying Ohio as a unified state was made and received extensive discussion, and thereafter consideration was postponed without setting a time for continuing the discussion.

FISCAL MATTERS

The Council **ratified and approved** individual telephone responses by the Council on July 16, 1976, regarding the Professional Liability Task Force survey contracts, by voting as a body to **ratify and approve** these contracts.

Dr. Robert G. Thomas was appointed fiduciary agent for the OSMA Corporate Employers Group Term Life Insurance plan to succeed Dr. James L. Henry.

AMERICAN MEDICAL ASSOCIATION

Dr. Robechek reported on the campaign to elect Dr. Lewis to the Vice Speakership of the American Medical Association.

Dr. Robechek asked for instruction to the AMA Delegation regarding a request that the National Association of Insurance Commissioners Quarterly Reports on closed malpractice claims not be discontinued as the one remaining source of this type information on a national basis. The Council was favorable to this request.

Mr. Campbell reported on plans for the Clinical Session of the House of Delegates in December.

Dr. Budd reported on developments in medicine at the national level. He suggested that the Association consider support for Dr. Albert B. Sabin for the scientific achievement award.

The Councilors were reminded of the AMA Leadership Conference, January 20-23, 1977, and were urged to attend and to encourage the officers of county medical societies to attend.

CONTINUING MEDICAL EDUCATION

Mrs. Dodson reported on the Regional CME meeting in Athens, Ohio, February 12 and 13, 1977, for Category I credit. A two-day program on Advanced Life Support will be held. In addition to this, three other courses on antibiotics, electrolytes and acid-base disturbances, as well as cardiology will be offered. A mailing to the entire membership will be sent in several weeks.

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Numerous meetings with the Ohio State Medical Board and with members of the Board with regard to mutual continuing medical education efforts were reported by Mrs. Dodson. Information on the continuing medical education program which has been certified by the Ohio State Medical Association and approved by the State Medical Board will be disseminated to OSMA members in the December issue of *The Journal.*

PICO

Mr. Gilmore addressed the Council concerning recent activities of The Physicians Insurance Company of Ohio. He also discussed the filing by Insurance Service Organization (ISO) of a rate increase effective November 1, 1976, and a communication from Medical Protective, Inc., of Fort Wayne, to Mr. Page concerning a rate increase by that organization in 1977.

President Bates announced that he had appointed, as Chairman of the Board of Directors of PICO, the following committees:

Finance and Budget: Dr. Thomas, Chairman; Drs. Henry and Wells, Mr. Pohlman, and Mr. Page.

Personnel: Dr. Gaughan, Chairman; Drs. Dunsker, Henry, and Payne, and Mr. Page.

COMMITTEE REPORTS

Committee on Prisons and Jails

Mr. Gillen reported on the September 29, 1976 meeting of the Committee on Prisons and Jails. These minutes were accepted.

The October 27, 1976 minutes were presented, and the Council **approved** the committee's recommendations with regard to sending an Inmate/Patient Profile form developed by the committee to each jail in Ohio.

The minutes, as a whole, **were approved.**

OSMA Employees Pension Committee

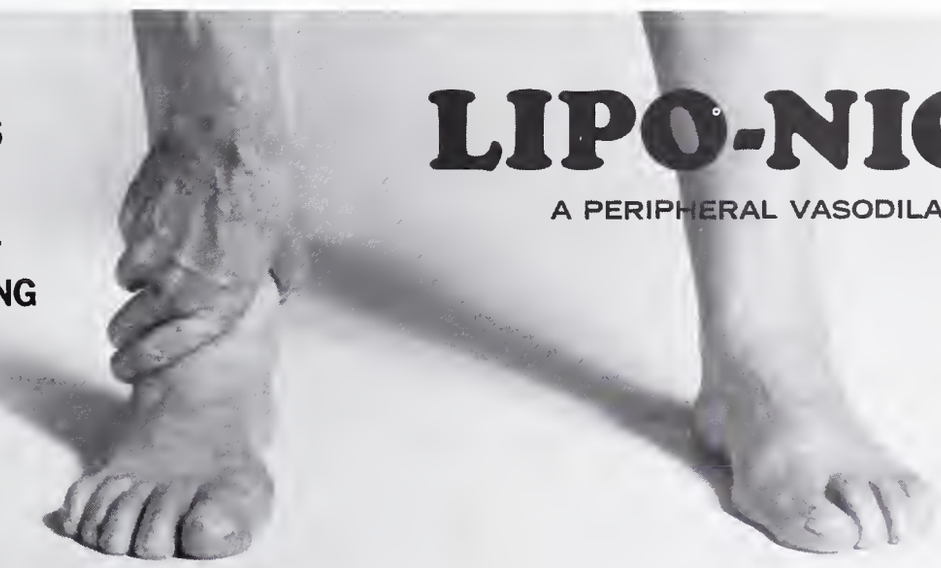
Mrs. Wisse presented the minutes of the September 29, 1976 meeting of the OSMA Employees Pension Committee.

These minutes covered the updating of the OSMA pension program to conform with the new Federal Pension Act provisions (ERISA).

The minutes **were approved.**

(continued on page 48)

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(continued from page 47)

Committee on Private Practice & Patient Care

Mr. Edgar reported on the October 20, 1976 meeting of the Committee on Private Practice and Patient Care. The report was accepted for information.

Joint Advisory Committee on Sports Medicine

Mr. Clinger reported on the October 20, 1976 meeting of the Joint Advisory Committee on Sports Medicine.

A recommendation to restructure the Joint Committee **was approved.**

A proposal for a sports medicine "forum" to be published in the *Ohio State Medical Journal* **was approved.**

The minutes, as a whole, were **approved.**

Committee on Health Manpower

The minutes of the Committee on Health Manpower "Think Session" held October 21, 1976 were presented by Mr. Clinger for the information of the Council.

Committee on Traffic Safety

Mr. Clinger presented the October 27, 1976 minutes of the Committee on Traffic Safety.

The Council **approved** a recommendation of the committee that OSMA support legislation to provide for compensation for members of the Medical Review Board of the Ohio Bureau of Motor Vehicles, similar to that provided to members of the Ohio State Medical Board.

The report, as a whole, **was approved.**

Committee on Government Medical Care Programs

Mr. Gillen reported on the HEW Medicaid audit and the investigations of Workmen's Compensation.

Ad Hoc Committee on Revision of the Constitution and Bylaws

The minutes of the Ad Hoc Committee on Revision of the Constitution and Bylaws meeting held November 5, 1976 were reported by Dr. Dorner.

The Council directed the committee to go ahead with the drafting of amendments to the Bylaws for submission to the 1977 meeting of the OSMA House of Delegates which would require, in order for ballots to be valid in at-large elections, that votes be cast for all positions.

Committee on Scientific Work

Dr. Roland A. Gandy, Jr., Toledo, was appointed to the Committee on Scientific Work to serve a term ending at the time of the Annual Meeting in May 1977. Dr. Robert G. Page, Toledo, resigned as a member of the committee to take a leave of absence outside of Ohio during 1977, creating a vacancy on the committee.

COUNCILOR REPORTS

The Councilors reported on activities in their respective districts.

Dr. Ford proposed monthly district meetings with OSMA Delegates and Alternate-Delegates in order to develop better communications throughout the federation.

Dr. Ford pointed out that the November 1976 election portends an era of transition and rapid changes and that the Ohio State Medical Association structure must be girded to meet and cope with these developments. He proposed, therefore, that OSMA establish a full-time Department of Federal Legislation in order to enhance the efficiency of the work of the Ohio State Medical Association with the American Medical Association and county medical society efforts in federal legislation.

These proposals were referred by the President to the Committee on Auditing and Appropriations for consideration at its December meeting.

FEDERAL LEGISLATION

Mr. Edgar reported that Congress had enacted legislation to establish the office of inspector general in the U.S. Department of Health, Education and Welfare, appointed directly by the President. Congress has asked that the office's first project be a thorough investigation of alleged Medicare and Medicaid abuses.

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He also recommended that the Council review thoroughly the detailed analysis of the 1976 Health Manpower Act previously provided the Council.

Mr. Edgar reported that the Federal Trade Commission is in the process of examining accreditation of medical schools, has commented negatively on the AMA's role, the Liaison Committee on Medical Education; and it is anticipated that the FTC will similarly examine involvement of the Association of American Medical Colleges in the accreditation process. Mr. Edgar said the FTC's activities are believed to be to set the groundwork for a federal takeover of medical school accreditation as a parallel to the movement to federalize medical licensure and relicensure.

Mr. Edgar referred the Council to a letter received from the Logan County Medical Society in which more OSMA activities were requested in alerting the public to the encroachment of government medicine. He said that more such requests could be expected from county medical societies and individual members if legislation to federalize all medical care is given a high priority in the 95th Congress.

PUBLIC RELATIONS

Mr. Edgar said the Committee on Public Relations and the Department of Public Relations already have activated a number of public information programs in the areas of medical and health information, and that meetings have been held with several county medical societies to help them establish comprehensive public information programs within their own areas, and that this service is available to any county medical society that requests it.

Ms. Doll reported that the first in a series of radio tapes was sent to about 24 stations around the state, two in each councilor district. She said that all but one station had agreed to use the tapes and that a tape covering about five topics would be sent, along with a written script, to stations every three to four months.

She encouraged Councilors to submit ideas for these tapes, as well as for the weekly and Sunday newspaper health columns and for the patient publication, *Your Doctor Reports*. She mentioned that WCOL radio in Columbus had provided their production services at no charge to the OSMA, and Dr. Pfahl made a motion that a letter of appreciation from the Council be sent to WCOL.

STATE LEGISLATION

Mr. Mulgrew reported on the make-up of the 112th Ohio General Assembly, which convenes in January 1977, and discussed probable legislative issues.

The Council authorized the President to appoint an Ad Hoc Committee on Quality Care. Dr. Ford was named chairman, with the remainder of the committee to be announced at a later date.

(continued on page 50)

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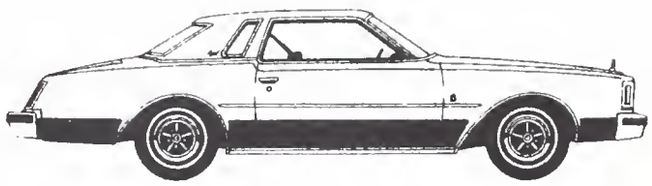


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(continued from page 49)

LEGAL COUNSEL REPORT

Mr. Pohlman reported on lower court challenges to House Bill 682, the Omnibus Professional Liability Act.

FIELD SERVICE

Mr. Holcomb reported on 33 field service visits in 11 districts since the September 25-26, 1976 Council meeting and announced the schedule of future visits into 1977.

OHIO STATE MEDICAL JOURNAL

The Council **approved** the coverage of the osteopathic school in Athens in OSMA *Journal* articles on Ohio's medical schools.

Approved by the Council was the concept of receiving grants from voluntary health organizations to cover publication costs of scientific articles on their specific fields, subject to the editorial judgment of the Consulting Medical Editor.

TASK FORCE ON PROFESSIONAL LIABILITY

Dr. Bates announced the appointment of the following Councilors to the Advisory Committee on Countersuits: Dr. Pichette, Chairman; Drs. Diller, Lewis, Morgan, and Pfahl.

The Council discussed the announcement of the Insurance Service Organization (ISO) filing for a rate increase. The Council voted to oppose the new ISO rate filing through both the development of a public release and, if necessary, a request for a public hearing to be held by the Department of Insurance. Mr. Mulgrew was instructed to request OSMA consulting actuaries to prepare an analysis of the new filing.

Further discussion was held regarding current decisions affecting the Omnibus Professional Liability Act and the Council authorized legal counsel and the Department of State Legislation to proceed with the filing of *amicus curiae* briefs in appropriate cases where challenges to the legislation have been made.

Mr. Campbell announced the formation of the Ohio Products Liability Council consisting of 22 associations.

Mr. Campbell then presented his report on current JUA information.

OSMA AUXILIARY

Mrs. William A. Myers, Circleville, President of the Ohio State Medical Association Auxiliary, addressed the Council with regard to the work of the Auxiliary, the concerns of that organization, and its proposals for the future. Mrs. Myers received the acclaim of the Council, and the Auxiliary was commended on the excellence of its broad-scope activities in behalf of medicine.

OMPAC

Mr. Rader reported on the Ohio Medical Political Action Committee and announced that membership in this organization reached an all-time high during the current year. He indicated that an expanded program could be expected next year.

OHA COST CONTAINMENT COMMITTEE

Dr. Bates and Dr. Wells were appointed as OSMA representatives to serve on an Ohio Hospital Association Committee being formed to address the general subject area of cost containment.

SUDDEN INFANT DEATH

In answer to a request from Dr. John H. Ackerman, Director, Ohio Department of Health, Dr. Bates, on recommendation of the Subcommittee on Maternal and Neonatal Health, appointed Dr. Robert J. Keck, a Columbus pediatrician, to represent the Ohio State Medical Association on a Sudden Infant Death interest group to discuss legislation on this subject.

NEW STAFF MEMBER

Mr. Rick Ayish, newly employed Assistant Director of the Department of State Legislation, was introduced to the Council.

ADJOURNMENT

There being no further business, the meeting was adjourned. ATTEST: Hart F. Page
Executive Director



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Representatives and Senators In the Ohio Legislature and The United States Congress

The Democrats captured a "veto-proof" Ohio Legislature in the November 1976 election by winning 62 of 99 seats in the House and 21 of 33 seats in the Senate. All Ohio House Democrat incumbents were returned. In addition, Democrats won the following House seats: 59th District (part of Lake County)- Edward J. Hughes; 63rd District (part of Greene County)- James S. Zehner; and 44th District (part of Summit County)- Thomas Sawyer.

In the Ohio Senate, the Democratic majority remained the same but four districts changed party hands. Mark Roberto (D-Ravenna) defeated Dave Johnson (R-Canton) in the 18th District, and John Mahoney (D-Springfield) defeated Max Dennis (R-Wilmington) in the 10th District. These changes were offset by Republican victories by Paul Pfeifer (R-Bucyrus) in the 26th District and Sam Speck (R-New Concord) in the 20th District. In addition, two State Senators were elected to the U.S. Congress: Doug Applegate (D-Steubenville) and Don Pease (D-Oberlain). Their replacements in the Senate were Democrats, and, thus, the Democrat/Republican totals remained the same as in 1976.

The Ohio Delegation to the U.S. Congress was reduced by three Republican members with the election of Mr. Pease and Tom Luken (D-Cincinnati), respectively to the seats held by Charles A. Mosher (R-Lorain) and Don Clancy (R-Cincinnati) and the defeat of Robert Taft by Howard Metzenbaum in the race for Ohio's Senate seat.

The following pages contain lists of Ohio's state and national representatives, by district, with their current address and telephone number.

U.S. Senators

HOWARD M. METZENBAUM (D)
17 Investment Plaza, Cleveland 44114
216/696-4666

JOHN H. GLENN (D)†
85 Marconi Blvd., Columbus 43215
614/469-6697

U.S. Representatives

1st WILLIS D. GRADISON, JR. (R)*
550 Main St., 8008 Federal Office Bldg., Cincinnati 45202; 513/684-2456

2nd THOMAS A. LUKEN (D)
1161 Larmon Ct., Cincinnati 45239
513/621-3394

3rd CHARLES W. WHALEN, JR. (R)*
228 Beverly Place, Dayton 45419
513/225-2843

4th TENNYSON GUYER (R)*
1196 E. Sandusky St., Findlay 45840
202/225-2676

5th DELBERT L. LATTA (R)*
516 Hillcrest Ave., Bowling Green 43402; 202/225-6405

6th WILLIAM H. HARSHA (R)*
2021 Sunrise Ave., Portsmouth 45662
202/225-5705

7th CLARENCE J. BROWN (R)*
430 Scioto St., Urbana 43078
513/653-3263

8th THOMAS N. KINDNESS (R)*
328 South D St., Hamilton 45013
202/225-6025

9th THOMAS L. ASHLEY (D)*
2836 River Rd., Maumee 43537
202/225-4146

10th CLARENCE E. MILLER (R)*
434 Cannon House Office Bldg., Washington, D.C. 20505; 202/225-5131

11th J. WILLIAM STANTON (R)*
7 N. Park Pl., Painesville 44077
216/352-6167

12th SAMUEL L. DEVINE (R)*
195 N. Roosevelt Ave., Columbus 43209; 614/221-3533

13th DONALD J. PEASE (D)
285 Oak St., Oberlin 44074
216/775-1611

14th JOHN F. SEIBERLING (D)*
2 S. Main St., Akron 44308
216/375-5710

15th CHALMERS P. WYLIE (R)*
1019 Spring Grove Lane, Columbus 43085; 202/225-2015

16th RALPH REGULA (R)*
8787 Erie Ave., SW, Navarre 44662
216/879-2105

17th JOHN M. ASHBROOK (R)*
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202/225-6431

18th DOUGLAS APPLEGATE (D)
Rt. 3 Berkley Place, Steubenville 43952; 614/264-1012

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2405 Volney Rd., Youngstown 44511

20th MARY ROSE OAKAR (D)
1892 W. 30th St., Cleveland 44113

21st LOUIS STOKES (D)*
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22nd CHARLES VANIK (D)*
24799 Lake Shore Blvd., Euclid 44123; 202/225-6331

23rd RONALD M. MOTTL (D)*
7713 Wake Robin Dr., Parma 44130
202/225-5731

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304 Third St., Defiance 43512
419/782-0481

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2253 Sand Rd., Port Clinton 43452
419/447-2521

3rd THEODORE M. GRAY (R)†
4735 Widnor Ct., Columbus 43220
614/451-8602

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1066 E. Park Lane, Middletown 45042; 614/266-8072/8074

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4200 Overland Trail, Dayton 45429; 614/466-5131

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8560 Gwilada Dr., Cincinnati 45236
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220 Wyoming Ave., Cincinnati 45215; 513/241-0400

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(continued on page 52)

D Democrat
R Republican
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† Holdover

Ohio's State Legislators *(continued)*

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518½ Homeview Ave., Springfield 45505; 513/325-8281

11th MARIGENE VALIQUETTE (D)†
3211 Parkwood Ave., Toledo 43610
419/243-9773

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1014 11th St., Lorain 44052
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150 N. Riverside, Batavia 45103
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3068 Stanwin Pl., Cincinnati 45241
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721 Salem Ave., Dayton 45406
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35th TOM L. FRIES (D)*
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2815 Lake Shore Pl., Apt. 402,
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38th ROBERT L. CORBIN (R)
3147 Far Hills Ave., Dayton 45429
513/298-9511

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3395 Purdue St., Cuyahoga Falls
44221; 216/375-7405

40th THOMAS C. SAWYER (D)
508 Patterson Ave., Akron 44310
216/376-2332

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6209 Dawson Blvd., Mentor 44060
216/257-2443

60th DAVID HARTLEY (D)*
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45503; 614/466-3787

61st SHERROD BROWN (D)*
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216/376-9172

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614/460-8066

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513/836-6893

68th JOHN E. JOHNSON (D)*
687 Wadsworth Rd., Orrville 44667
216/683-1181

69th JOHN A. GALBRAITH (R)*
602 Pierce St., Maumee 43537
419/893-4621

70th JOHN H. KELLOGG (R)*
168 S. Maple St., Orwell 44076
216/437-5136

71st THOMAS J. CARNEY (D)*
60 Melrose Ave., Boardman 44512
216/746-8861

72nd MARIE TANSEY (R)
1201 State St., Vermilion 44089
216/967-4568

73rd CORWIN M. NIXON (R)*
P.O. Box 58, Lebanon 45036
513/932-5781

74th DENNIS L. WOJTANOWSKI (D)*
8437 Mayfield Rd., Chesterfield
44026; 216/729-9777

75th CHARLES R. SAXBE (R)*
177 E. Sandusky St., Mechanicsburg
43044; 513/834-5555

76th HARRY E. TURNER (R)*
400 E. Vine St., Mt. Vernon 43050
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124 Joy Ave., Hillsboro 45133
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P.O. Box 272, Huntsville 43324
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611 West South St., Bryan 43506
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Box 356, Anna 45302
513/394-2923

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2750 Pemberton Rd., Laura 45337
513/947-1112

82nd MICHAEL G. OXLEY (R)*
301 E. Main Cross St., Findlay
45840; 419/422-8713

83rd CHARLES F. KURFESS (R)*
9449 Reitz Rd., Rt. 1, Perrysburg
43551; 419/352-1933

84th FREDERICK H. DEERING (D)*
9610 Ranson Rd., Monroeville
44847; 419/359-1192

85th GENE DAMSCHRODER (R)*
365 SR 53, Fremont 43420
419/332-8037

86th WALTER D. McCLASKEY (R)*
3434 Marion-Marysville Rd.,
Marion 43302; 614/389-1474

87th HARRY C. MALOTT (D)*
R.R. #2, Box 33, Mt. Orab 45154
513/724-2100

88th MYRL H. SHOEMAKER (D)*
Bourneville 45617; 614/626-7985

89th VERNAL G. RIFFE, JR. (D)*
703 Lakeview Ave., New Boston
45662; 614/456-4191

90th DON S. MADDUX (D)*
135 Berkeley Dr., Lancaster 43130
614/466-4895

91st CLAIRE M. BALL, JR. (R)*
19 West Washington St., Athens
45701; 614/593-5591

92nd RONALD H. JAMES (D)*
Rt. 2, Box 195, Proctorville 45669
614/466-8010

93rd WILLIAM G. BATCHELDER
(R)*; 124 W. Washington St.,
Medina 44256; 216/725-6666

94th REX F. KIEFFER, JR. (R)*
2201 Dresden Rd., Zanesville 43701
614/466-3780

95th THOMAS W. JOHNSON (R)
R.R. #6, Cambridge 43725
614/432-6311

96th WILLIAM E. HINIG (D)*
150 S. Broadway, New Philadelphia
44663; 216/343-1312

97th ROBERT J. BOGGS (D)*
RFD 2, Box 30F, Jefferson 44047
614/466-3919

98th ARTHUR R. BOWERS (D)*
Eft's Lane, Steubenville 43952
614/264-1271

99th A. G. LANCIONE (D)*
Professional Complex, 35th &
Jefferson Sts., Bellaire 43906
614/676-2034

Ohio State Medical Association

BUDGET FOR 1977

The Ohio State Medical Journal	$ 58,162.05
Salaries	493,700.00
Employees Fringe Benefits	32,092.46
Staff Expense	48,600.00
President: Expense and Honorarium	12,000.00
President Elect: Expense and Honorarium	7,000.00
Past President: Honorarium	2,000.00
Secretary-Treasurer: Honorarium	2,000.00
Council Expense	20,000.00
AMA Delegate-Alternate Expense	39,050.00
COMMITTEES:	
Ad Hoc Complaint	–0–
Auditing and Appropriations	6,200.00
Cancer	300.00
Emergency & Disaster Medical Care	600.00
Education	1,380.00
Education: Commission	14,040.00
Environmental and Public Health	300.00
Eye Care	940.00
Family Practice Scholarships	4,800.00
Federal Legislation	2,500.00
Government Medical Care Programs	2,500.00
Health Manpower	1,000.00
Hospital Relations	500.00
Insurance	500.00
Jails and Prisons	1,500.00
Judicial and Professional Relations	200.00
Laboratory Medicine	650.00
Maternal Health	3,100.00
Medicine and Religion	200.00
Membership and Planning	12,800.00
Mental Health	2,500.00
Organ Transplant	500.00
Placement Service	–0–
Private Practice	500.00
Public Relations	400.00
Rehabilitation	100.00
Rural Health	500.00
School Health	1,200.00
Scientific Work	2,800.00
Special Education	150.00
Sports Medicine	2,500.00
State Legislation	1,200.00
Traffic Safety	500.00
Workmen's Compensation	700.00
Annual Meeting	69,705.00
Building Expense	63,060.00

Car Lease Expense	11,705.00
Councilor District Conferences	3,000.00
Data Processing	20,000.00
Emergency Fund	7,066.37
Equipment Rental	26,775.00
Field Service	3,980.00
Insurance and Bonding	10,480.00
Interest	12,371.44
Legal Expense	90,000.00
Library	1,800.00
Meeting Expense	16,850.00
OSMAgram	16,500.00
Postage	26,625.00
Professional Relations Activities	5,200.00
Public Relations	24,000.00
Supplies: Misc.	3,981.00
Supplies: Office	19,071.00
Taxes: Payroll	27,125.00
Telephone & Telegraph	32,000.00
Furniture and Equipment	24,850.00
Depreciation	20,000.00
TOTAL BUDGET FOR 1977	**$1,318,309.32**

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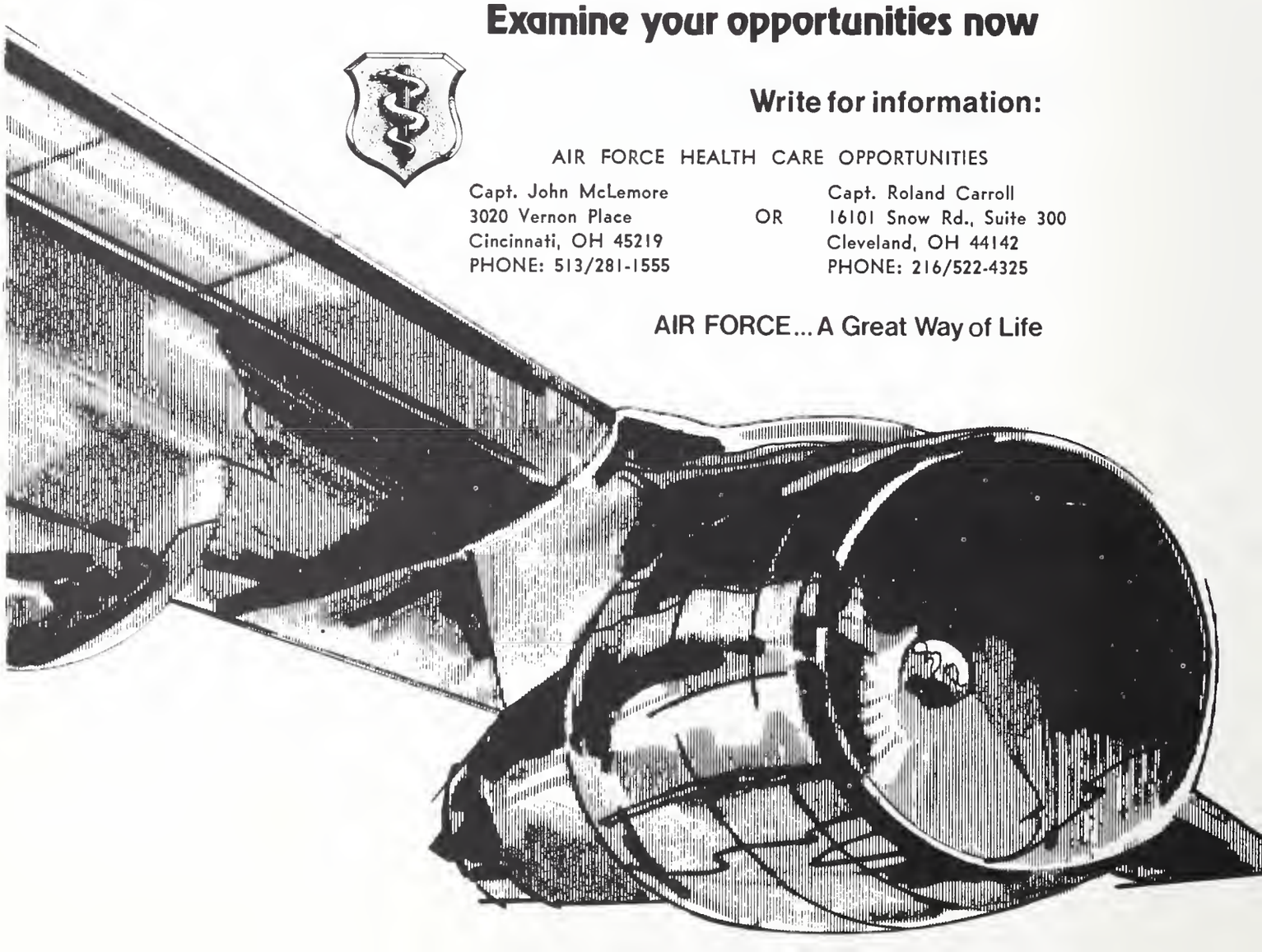
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THE OHIO STATE Medical Journal

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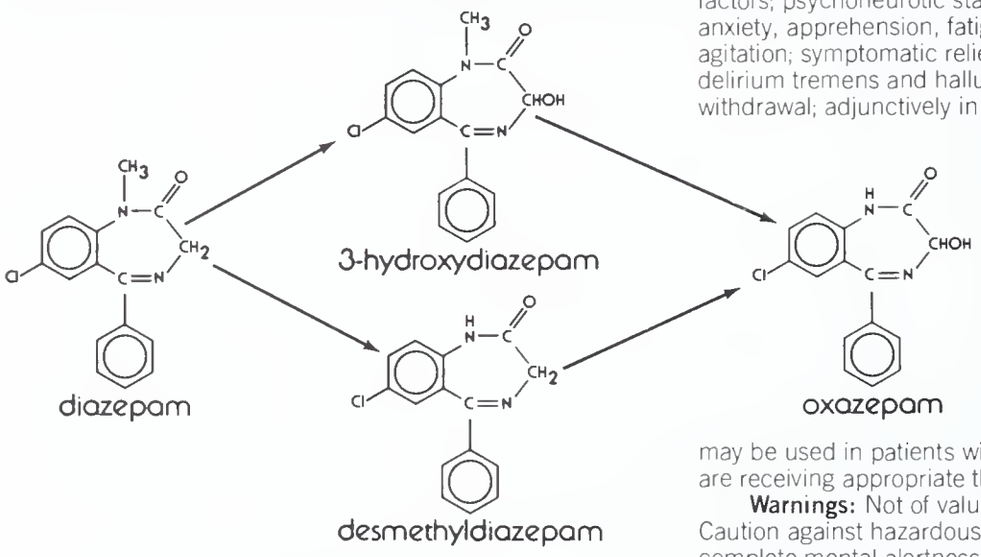
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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Ohio Energy Shortage

Governor James A. Rhodes, on January 27th, declared a statewide energy crisis to deal with the current natural gas shortage.

House Bill 584, enacted by the 111th General Assembly, gives the Governor the authority to declare a crisis when he finds the health, safety, or welfare of the citizens of Ohio threatened by an actual or impending acute shortage of usable energy resources. The order gives the Governor control over both energy sources and political subdivisions and permits mandatory restrictions on the energy consumption of the citizens and businesses of Ohio.

In an effort to find an immediate solution to the acute energy problem, a special session of the General Assembly was called January 25th to study the energy shortage. The result of the extraordinary session was a declaration of cooperation between the Ohio Legislature and the Governor. The Legislature endorsed the Governor's request for all Ohioans to join in the statewide effort to conserve energy voluntarily.

It is hoped that cooperation with the voluntary energy conservation requests of the Governor and the Legislature will be enough to see Ohio through the natural gas crisis of the severe winter.

New Look to Legislative Health Committees

The new legislative session has brought changes in the last session's committee structure by the creation of new standing committees in both the House and Senate.

The Senate combined two standing committees this session, establishing the Education and Health Committee with Assistant Majority Leader Morris Jackson (D-Cleveland) as chairman.

Last session's House Human Resources Committee, chaired by Representative Phale Hale (D-Columbus), has remained unchanged. The House leadership created a new Health and Retirement Committee with Representative John Thompson (D-Cleveland) named chairman.

These three committees will hear most of the matters of concern to the OSMA.

The OSMA strongly encourages Ohio physicians to contact their local legislators to express concern or support for legislative issues. This type of communication, as well as contact with the OSMA Department of State Legislation, greatly contributes to the advancement of medicine and our society.

House Health & Retirement Committee

John Thompson (D-Cleveland) **Chairman; Larry Christman** (D-Englewood) **Vice Chairman;** Ronald James (D-Proctorville); Don Maddux (D-Lancaster); Les Brown (D-Columbus); Fred Deering (D-Monroeville); A. G. Lancione (D-Bellaire); Ike Thompson (D-Cleveland); Mack Pemberton (R-Columbus); John Galbraith (R-Maumee); Richard Finan (R-Cincinnati); Robert Taft, Jr. (R-Cincinnati); and William Donham (R-Middletown).

House Human Resources Committee

Phale Hale (D-Columbus) **Chairman; David Hartley** (D-Springfield) **Vice Chairman;** James Rankin (D-Cincinnati); Dennis Wojtanowski (D-Willoughby Hills); Clifton Skeen (D-Akron); John Bogala (D-Kent); James Zehner (D-Yellow Springs); Richard Maier (R-Massillon); Irma Karmol (R-Toledo); Michael Fox (R-Hamilton); and Robert Corbin (R-Dayton).

Senate Education & Health Committee

Morris Jackson (D-Cleveland) **Chairman; Marcus Roberto** (D-Ravenna) **Vice Chairman;** Anthony Celebrezze, Jr. (D-Cleveland); John Mahoney (D-Springfield); Ronald Milleson (D-Freeport); Neal Zimmers, Jr. (D-Dayton); Oakley Collins (R-Ironton); Ben Gaeth (R-Defiance); and Sam Speck (R-New Concord).

Anesthesiologists Draft Assistant Legislation

In response to a statement by the Ohio State Medical Board that "there is no authority under Ohio's statutes for anesthesiologists' assistants," a group of Cleveland anesthesiologists are preparing legislation to permit these assistants to administer anesthesia.

The present problem has been created as a result of the development of an anesthesiologist assistant program at Case Western Reserve University. This program graduates an average of 12 students per year with a bachelor degree, indicating specialized academic courses in basic medical science as it applies to the administration of anesthesia.

At present, the OSMA Committee on Health Manpower is reviewing the problem and the proposed legislative solution. The new statement of the State Medical Board does not apply to nurse anesthetists who presently have a legislative exclusion from the practice of medicine under 4731.35 O.R.C.



the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

Washington lawyer Joseph Califano, Jr., one of Lyndon Johnson's top "Great Society" architects, has been named Secretary of HEW. The 45-year-old native of Brooklyn knows most of the programs— many of them established during the "Great Society" days— that he will now administer. Liberals, including Ralph Nader, saw in Califano's "Great Society" background a promise of a bigger and better "Great Society"; conservatives found reassurance in Califano's reputation as a steady political veteran who is interested in cutting down on waste and inefficiency. If Carter carries out his promise to give his department heads plenty of rein in policy matters, Califano might emerge as the chief policy architect in health affairs.

Medical Price Controls

A concerted, united effort by industry and labor to control medical costs is needed to avert federal takeover of health which would "result in national expenditures of truly astronomical proportions," contends the President's Council on Wage and Price Stability.

In a lengthy report on rising health care costs, the Council said, "Cost control incentives proposed by the private sector— that is, by industry and labor— promise to be more effective than those imposed by the multitude of government agencies which have attempted to tackle the problem . . . the private sector is motivated by an economic incentive which the government will simply never share."

The report indicated that the government, in its Medicare and Medicaid programs, has a poor record of controlling costs. "The blizzard of rules and regulations which would accompany full federal financing and administration of the health industry would add to costs and reduce the limited incentives that now exist for efficiency and cost containment," the Council said.

Senator Praises AMA

The AMA and state and local medical associations "have played a central role" in helping the Senate spotlight Medicaid fraud and abuse said Senator Frank Moss (D-Utah), Chairman of the Senate Aging Subcommittee that conducted the well-publicized investigations of "Medicaid Mills" earlier this year. The Senator also said "the number of physicians who cheat" is very small.

In a letter to Richard E. Palmer, M.D., President of the AMA, Moss said: "The Illinois Medical Society, the Chicago Medical Society, and the Illinois Physicians' Union were directly responsible for my subcommittee's exposure to the problem of Medicaid 'Mills.' "

The abuses highlighted in the subcommittee's report "exist for many reasons, but AMA inaction isn't one of them," said Moss.

The Senator said the subcommittee's criticism "was not directed at contemporary medical practice."

"It was directed at a growing aberration in our urban ghettos called the Medicaid 'Mill.' The culprits we identified are greedy businessmen and real estate speculators . . . the same people we found pyramiding nursing home mortgages in New York. Now they have found a new gravy train. They hire foreign-trained physicians (we include podiatrists and chiropractors in the definition) and pressure them to see more and more patients in less and less time. The entrepreneurs keep from 50 to 70 percent of the money Medicaid pays to the foreign practitioner. . . . "

Drug Abuse

Drug abuse remains a "chronic, persistent problem" in the United States with no simple solution in sight, in the opinion of a joint annual report by federal agencies involved with drugs. The report proposed no basic shift in federal policy toward drug abuse, but suggested the possibility of lifting or easing criminal penalties for smoking marijuana.

The Strategy Council on Drug Abuse declared the government "ought to strongly discourage the use" of marijuana. President Jimmy Carter said, during his campaign, he favored decriminalization of possession of small amounts of the product, but he supported continued crackdowns on sale and distribution.

According to the report, marijuana carries a "relatively low social cost." Some 22 million Americans smoked marijuana last year, a "saturation" total that should prod the federal government into a decision on continuing to approach its use on a criminal basis.

Medical Records

Congress is showing increased interest in the problems of maintaining confidentiality of medical records in the age of computers and vast federal medical programs. The House Commerce Subcommittee on Oversight and Investigations is considering hearings on the issue next year.

The most serious evidence of abuse so far came with state grand jury indictments in Denver, Colorado, of an investigation company— Factual Service Bureau, Inc.— on charges of selling confidential records to large insurance firms. Factual was alleged to have had agents who were able to penetrate the records of the FBI and the IRS, among others.

AMA Bill Backed

The American Association of Ophthalmology (AAO) has endorsed the national health insurance plan backed by the AMA. The Association said ophthalmologists support the concept of legislation proposed by the AMA which "federalizes Medicaid, makes available variable tax allowances toward the purchase of health insurance depending on the taxpayers' taxable income, and offers catastrophic insurance to all."

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VOL. 73 FEBRUARY 1977 NO. 2

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

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COVER: Make plans now to attend the 1977 OSMA Annual Meeting, May 14-18, in Columbus, Ohio. The headquarters hotel is the Sheraton-Columbus, and the co-headquarters hotel is the Neil House. The OSMA Auxiliary will have its headquarters in the Christopher Inn. (A hotel reservation form appears on page 101 of this issue.) The OSMA Committee on Scientific Work is planning numerous educational programs including several to take place Saturday, May 14. This new format will include courses in negotiating and public speaking. Contact the OSMA Headquarters, 600 S. High Street, Columbus, phone 614/228-6971, for further information.

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Clinical and Scientific

Ten Years' Experience With Outpatient Office Surgery

H. William Porterfield, M.D.
Lester R. Mohler, M.D.
James W. Ferraro, D.D.S., M.D.
Gerald A. Drabyn, M.D.

A ten-year experience in outpatient office surgery is presented representing 10,701 cases of which 2,939 were performed under general anesthesia and 7,762 under local anesthesia. It describes the experience of a plastic-surgery group practice with a facility in which one-half of the surgical cases were performed in this setting and the others required standard hospitalization care.

Strict criteria in the selection of cases to be operated on in this setting is emphasized; the need for competent anesthesia standards and services is stressed; and the significant cost savings to the patient and his insurance carrier is discussed.

Extreme care in the implementation of this type of health care program is recommended, and the potential for increasing outpatient hospital surgical services is stressed. The insurance industry is urged to be more responsive to the potential for outpatient services.

Editor's Note.—The need to reduce hospital costs (labor, personnel, supplies, equipment replacement) is of great concern to the medical profession, the lay public, legislative bodies, and the insurance industry. Over a period of ten years, the authors have demonstrated creativity in the successful operation of an ambulatory surgical facility. Our colleagues should give heed to the potential of this program. **R.L.M.**

OUTPATIENT SURGERY is becoming increasingly important in the spectrum of today's health care because of its very obvious impact on costs. The efforts to increase the use of outpatient surgery in the hospital setting are critically important at this time, but also of equal importance is the use of outpatient surgical care in the appropriate office setting. This paper presents a ten-year experience in outpatient surgery, outlines strict criteria required to successfully provide this kind of service, and discusses the potential cost savings afforded by this method of health care while maintaining quality care.

Historical Background

In 1965, with two former partners (J. C. Trabue, M.D., and J. L. Terry, M.D.), we elected to construct an office building primarily for the use of our single-specialty practice, plastic surgery, with additional space for rental use. During the evolution of this building concept, faced with the uncertainty of the hospital bed situation in 1965 and with the advent of Medicare, we decided to incorporate an office surgery facility within our own office suite. Unfortunately, there were no models to be used at that time; thus, the development of the facility required our own input along with that of an ingenious architect-designer and a tolerant contractor. We concluded that there was a need for surgical procedures under both local and general anesthesia. This, then, required consultation with anesthesiologists who guided us in the design of a facility that would allow for safe anesthesia and, at the same time, meet the code qualifications required for operating-room construction.

The result of this planning process was the development of a basic operating room, 19 X 19 ft., with a support area housing a standard, hospital-type sterilizer, appropriate instrument cleaning and storage areas, and a recovery room facility. This construction required piped-in oxygen for the recovery room and oxygen and nitrous oxide for the anesthesia machine. Conductive flooring was not used because the anesthesiologists declined to use explosive or flammable agents that might prove to be hazardous; therefore, this type flooring would have been an unnecessary expenditure. All other safety precautions

(electrical outlets, separate heating and air conditioning systems, and the establishment of appropriate monitoring processes with pulse and electrocardiogram monitors, a defibrillator, and all necessary medications) were determined prior to the construction. In recent remodeling, the original recovery area has been converted to a minor operating room and an expanded recovery room added. (See Figure.)

Prior to operation of the facility, it was determined that the anesthesia group would have total control over case selection regarding the safety of the patient. Therefore, it became exceedingly important to evolve a plan of appropriate case selection for any case scheduled in this facility. Each patient was to have a preoperative, complete blood cell count and urinalysis the day of his surgical procedure; a history and physical examination performed by the anesthesiologist and appropriately recorded; proper operating-room, anesthesia, and recovery-room notes made; and the patient appropriately discharged from the facility. Retrospectively, this decision to develop such a plan and its continued function without deviation has resulted in quality patient care. To date, no case has required transfer to a hospital for admission following surgery in this facility.

The selection and use of local anesthesia became the entire responsibility of the operating surgeon. Again, proper case selection and evaluation are essential for the success of this type of service. Similar appropriate records are maintained for the local anesthesia cases as are maintained for the general anesthesia cases.

Procedures Performed

In a plastic surgery practice, there are many cases that lend themselves to outpatient care in the proper facility with appropriate management. In the period from 1966 to 1975, we have performed 10,701 procedures in our facility. Of these, 7,762 were under local anesthesia and 2,939 were under general anesthesia.

It is our feeling that very strict criteria are required for the implementation of local anesthesia procedures in an office setting. These procedures must be performed in a far more elaborate and sophisticated manner than is indicated by a simple treatment room which has been used traditionally for the removal of a mole or a cyst. We have established the following criteria which we feel are necessary for the safe and proper use of outpatient, local anesthesia procedures: (1) properly equipped operating room and aseptic conditions for patients and attendants; (2) appropriate resuscitation and monitoring equipment; (3) adequate recovery facilities; and (4) appropriate records.

Many of the patients needing local anesthesia are given either intravenous or intramuscular sedation to allay their anxieties and apprehension. Xylocaine,® 1 percent with 1:200,000 epinephrine, is the most common anesthetic agent used in the facility; there have been no adverse drug reactions to date.

A representative list of the types of surgery that can be performed under local anesthetic in this facility includes reconstructive otoplasties, blepharoplasties, facelifts, scar revisions, skin grafts, and excision of malignant or benign skin tumors.

As stated at the beginning of this paper, the development of the general anesthesia criteria was a joint project with a local anesthesiology group (Drs. A. S. Canowitz, L. T. Franklin, J. P. Garvin, L. E. Imboden, J. B. Siddall, P. E. Vanik, E. J. Warner, and J. W. Woods). Case selection and proper technique in anesthesia with competent postoperative care provide the patient with a very safe and convenient means of surgery. A representative list of cases performed under general anesthesia in this facility includes augmentation mammoplasties, blepharoplasties, facelifts, reconstructive otoplasties, scar revisions, mastopexies, skin grafts, hand reconstructions, tendon repairs/grafts, removal of malignant or benign skin tumors, and facial fractures. The methods of anesthesia used in this ten-year period are outlined in Table 1.

None of the patients operated on in this setting was given preoperative medication. This has been most effective in reducing recovery room time, post-operative nausea and vomiting, and general problems that ensue when these medications are utilized. The psychologic status of the patient when he arrives for his surgery seems to be much improved in the office setting. He is returning to an environment with which he is acquainted and, therefore, he does not have the apprehensions and fears of the stark hospital setting. The patients range in age from infancy to the 60-year-plus group. (See Table 2.) As would be

TABLE 1. Anesthesia Methods—Ten Years

Type	Number of Patients
Mask	1,908
Oral-Endotracheal	338
Nasal-Endotracheal	132
Nasopharyngeal	473
Other	88
Total	2,939

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Submitted November 29, 1976.

expected from proper case selection and evaluation, the majority of the patients are under 50 years of age.

As 32 percent of the patients operated on in our facility were 12 years old or under (Table 2), children are exceedingly receptive to outpatient surgery. They arrive with their parents and remain with them in a waiting area until they walk or are carried to the operating room by the anesthesiologist. They wake up in the recovery room with their parents at hand. This "family concept" has been exceedingly effective and very well received by the families and young patients alike.

Criteria for outpatient-office, general anesthesia procedures must be more elaborate than those for local anesthesia patients. The following criteria were established at the opening of the facility and have been followed to date: (1) proper patient and case selection; (2) trained anesthesiologists; (3) properly equipped operating room and aseptic condition for patient and staff; (4) appropriate resuscitation and monitoring equipment; (5) adjacent recovery room; (6) laboratory availability, and (7) appropriate records. None of the patients has required hospital transfer or admission during this ten-year period.

Personnel

It is imperative that properly trained personnel be available in a setting of this nature. A qualified registered nurse is required to supervise the entire facility.

Personnel within the operating room may vary from surgical technicians to licensed practical nurses to registered nurses. It is essential, however, that a registered nurse be in a supervisory capacity over the personnel in the operating facility, whether or not she performs in that setting. The recovery room, likewise, must be staffed by a qualified and trained registered nurse. Secretarial personnel are needed in other areas to maintain adequate records and process the patient flow.

Table 2. Age Range—General Anesthesia Cases

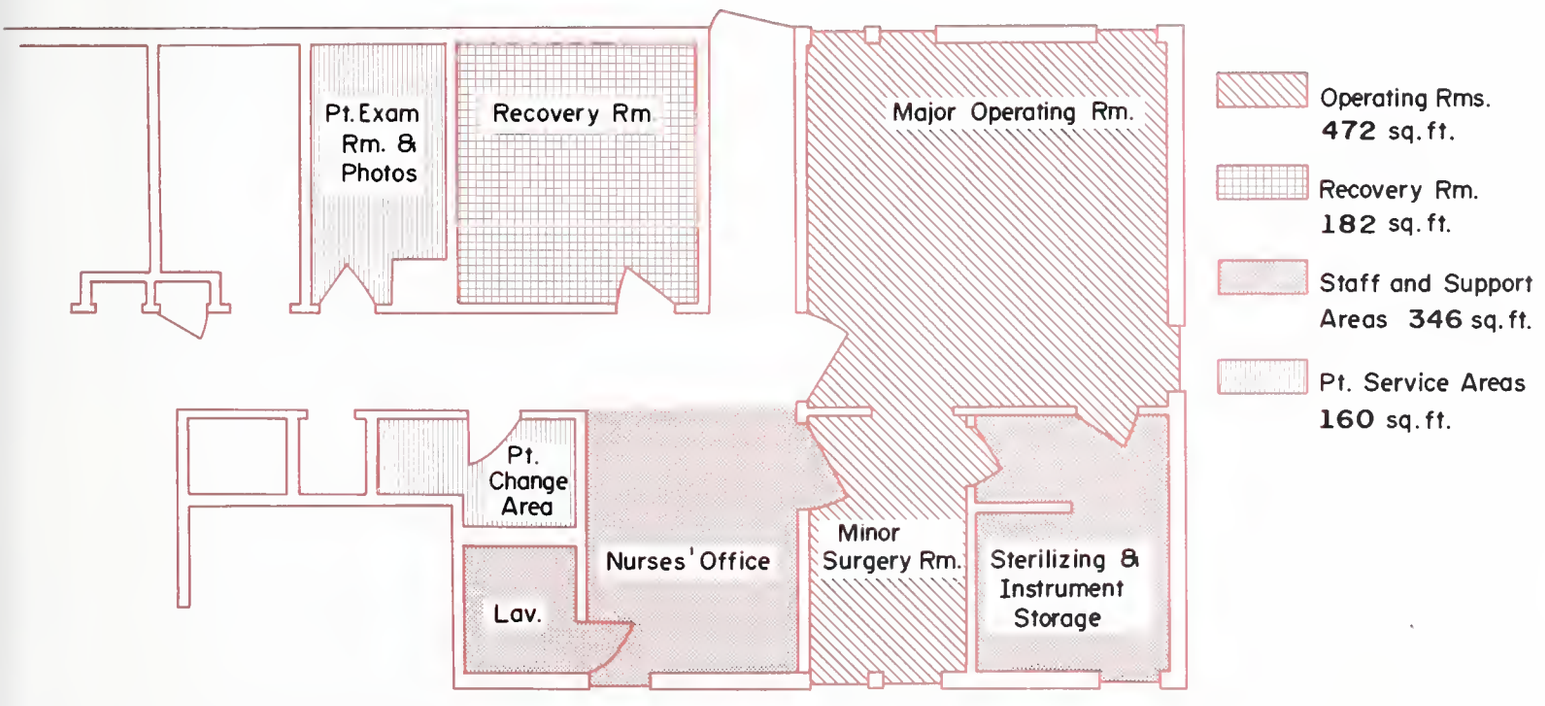
Years	Number of Patients
0 to 1	103
1 to 12	842
13 to 49	1,832
50 to 60	114
60 and over	48
Total	2,939

Cost

The basic factors of construction costs, operational expenses, and the problem of reimbursement are extremely important in a facility of this nature. Physicians generally are not too well informed in these areas, and they must become knowledgeable to function competently.

The basic construction costs can be quite variable, based on local code requirements and the degree of sophistication desired in the facility. However, fundamental equipment and structure requirements are inherent in the facility and, as a general rule, amount to approximately twice the standard office construction costs. For example, if basic office construction costs are $20 per square foot, an operating facility probably will cost $40 per square foot.

The continual problem of supplies, their availability and their cost, requires constant monitoring. We have



Floor plan of recently remodeled office facility showing operating room and support area.

Table 3. Comparative Costs—Local Anesthesia Cases

	One-Hour Case	Cost for 7,762 Cases	Two Days @ $100/Day ½ Cases Admitted	Possible Savings
Office O.R. facility	$50	$388,100	——	——
Hospital A	$85	$659,770	$1,435,970	$1,047,870
Hospital B	$96	$745,152	$1,521,352	$1,133,252

used disposable equipment in every possible manner throughout the ten years the facility has been in operation and have found this arrangement to be quite effective. Use of disposable equipment minimizes storage problems and eliminates the difficulty with laundering. Drapes, gowns, syringes, needles, and many other basic supplies can be obtained as disposables.

Additional items affecting the basic overhead of the facility include personnel, insurance, utilities, and equipment replacement.

Reimbursement for Services Rendered

Reimbursement has presented a serious problem and still is not totally resolved. The cost savings in our facility have been well documented, but some segments of the insurance industry still do not want to provide reimbursement for their policyholders. In some instances, the carriers are precluded from doing so because of the nature of specific contracts. For the first nine years of our operation, we submitted a single charge which covered the surgery as well as the facility cost. The patients were told that the charge was combined and that their insurance carrier might not pay the entire fee since it obviously would be higher than the separate surgical charge if performed in a hospital. However, most patients were willing to absorb the difference in cost because of the convenience and the reduction of other out-of-pocket costs to them (babysitters, motels, and other expenses) if they were hospitalized for a longer period of time.

Until outpatient facilities are properly accredited and certified, some insurance carriers may have difficulty in accepting the necessity for reimbursement. However, if all these patients were turned back to the hospital and operated on either as outpatients or inpatients, this certainly would have an impact on the expenditure by the carrier. Obviously, cost would be drastically higher; it seems appropriate for carriers to be concerned over the resolution of this matter of reimbursement for outpatient surgery facilities. We estimate that at least 80 percent of the patients discussed in this paper, by necessity, would be operated on in a hospital in most practices if facilities similar to ours were not available to the surgeon.

A word of caution: development of an office surgical facility never should be undertaken as an income-producing venture. At best, it offers convenience and efficiency to the surgeon and his patient.

Cost Savings Estimate

Tables 3 and 4 present comparative figures to emphasize the cost savings that are possible in this type of medical care delivery system. These are based on the cases performed and use our currently known cost factors as related to conservative inpatient and outpatient hospital charges. These figures do not take into consideration other cost savings to the patients and their families by reducing time off work, travel time away from home, extra family meals, motel bills, babysitter fees, and other expenses.

Table 3 compares the 7,762 cases of local anesthesia performed in our facility with the current figures of two major hospitals in our community. Since numerous cases operated on in our facility are customarily admitted by many surgeons, an additional comparison is made, at a conservative cost of $100 per day, with one-half of the cases admitted for a two-day hospital stay.

Table 4 compares the 2,923 cases of general anesthesia with the same two hospitals. Similarly, a comparison is made with those cases if admitted for a two-day stay.

Recommendations

It is our opinion that the development of an outpatient surgical facility within an office has limited application and can only be utilized effectively by those few surgical subspecialties whose potential outpatient work

Table 4. Comparative Costs—General Anesthesia Cases

	One-Hour Case Including One Hour Recovery Room	Total for 2,939 Cases	Two-Day Hospital Stay @ $100/Day	Possible Savings
Office O.R. facility	$ 80	$235,120	——	——
Hospital A	$127	$373,253	$960,053	$725,933
Hospital B	$114	$335,046	$922,846	$687,726

justifies the economy of the situation. The development of a more simplified structure limited to local anesthesia purposes would be more applicable overall and, at the same time, would be a significant cost-saving maneuver. In addition, convenience and accessibility greatly enhance the potential of the outpatient surgical facility.

Where several specialties or practices within a community utilize an outpatient facility, we believe it should be a facility operated by an anesthesiology group. It is imperative to have someone in charge who can limit the activities in the facility, control the quality of the services, and not be personally influenced by the ease and accessibility of the facility or directly concerned about its financial success.

Increasing the use of hospital facilities for outpatient care is very desirable and important if the medical community is to have some influence on costs and quality of service. However, before outpatient surgery can be further developed, the habit pattern of some individuals must be changed. In some instances, it may be difficult to get the cooperation of the hospital administration if the end result means vacant hospital beds. However, it is most desirable for hospital surgical staffs to evolve an efficient, cost-saving, outpatient surgical program. In many institutions, 10 to 30 percent or more of the daily surgical case load could become outpatient cases with the properly designed program.

Summary

We have presented a description of the development and management of a single-specialty, outpatient, surgical facility. Ten years' experience with 10,701 procedures has been documented; and recommended criteria for the use of outpatient surgery with local and general anesthesia is presented. Suggestions also are made for the development of hospital-outpatient, surgical programs.

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Localization of Abdominal Masses Using Ultrasound for Radiation Therapy

Ranjit S. Dhaliwal, M.D.
Antonio Rodriguez-Antunez, M.D.
Leopold Gonzalez, M.D.

A number of local failures after radiation treatment are attributed to the geographical miss of the tumor due to poor localization. The use of ultrasonography for deep-seated abdominal tumors is very helpful for precise localization and accurate treatment planning. The ultrasound unit can also be interfaced with a computer for direct transfer of information to design adequate portals for the tumor and, thus, spare other vital intra-abdominal organs.

THE DILEMMA OF RADIATION treatment planning for abdominal masses, when the dimensions and location of the tumor are not clearly defined clinically, still stands in the way of the radiation therapist. In spite of the awareness of the surgeons to mark the tumor with metallic clips during laparotomy, we occasionally find that this is not done. In these cases, we have found that the use of ultrasonography is valuable in designing the treatment portals.[1-5]

The following is a description of a method for localizing abdominal masses for treatment planning by the use of an ultrasound unit.

The planning for patients with carcinoma of the prostate is done by simulating the pelvic field of the patient in the treatment position, with his knees flexed, and inserting a lead marker at the anal margin. (Marked "M" in Figure 1.) A portal is designed here to include the pelvic nodes and to exclude the terminal 2.0 cm of the anal canal, determined with the help of the anal marker ("M"). (According to the national protocol, the prostate lies at 6.0 cm from the anus along the anterior rectal wall; this is counter-checked in each patient by a

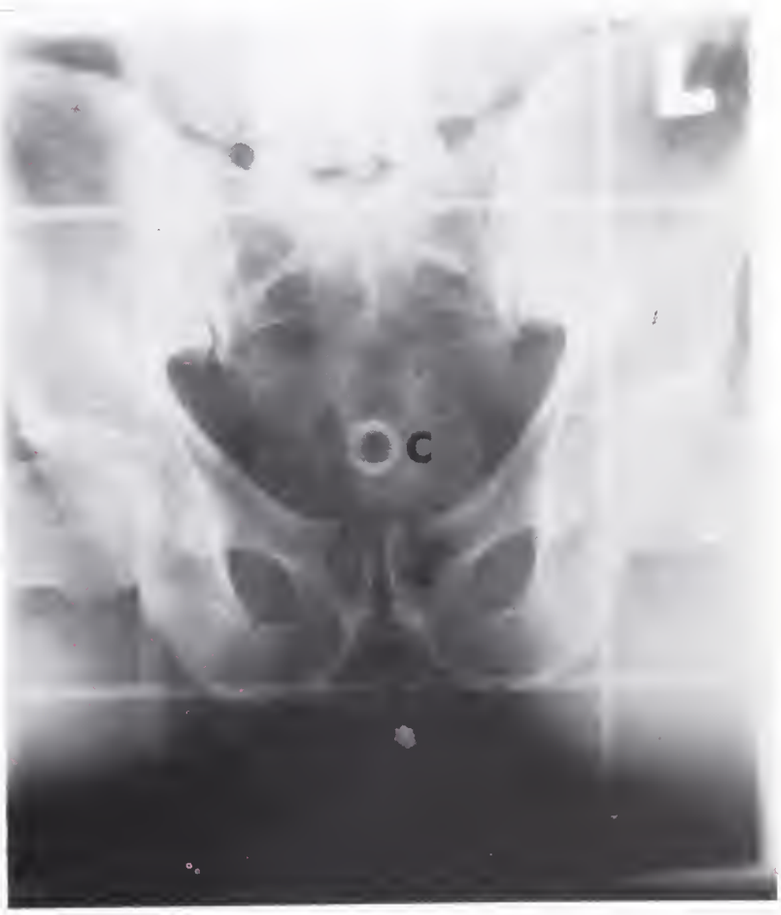


FIG. 1. Simulator x-ray picture of anteroposterior pelvic portal with lead marker at anus.

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rectal examination.) The anterior pelvic field then is marked on the skin of the abdomen of the patient. The patient now is scanned with the ultrasound in longitudinal and transverse planes in the treatment position, marking the anus "A" and the center of the anterior field "C" (Fig. 2).

The contour of the patient is directly transferred to the computer, which is interfaced with the ultrasound unit, along with the anteroposterior diameter of the patient and the size of the anteroposterior and posteroanterior portals. (The computer used here is the Artronix PC-12.™) At this point, a third small portal, 8X8 cm, is entered at an angle through the perineum to obtain a 100-percent dose in the area of the prostate (marked "P") as shown in Figure 2. In the case shown here, the perineal portal is entered at 30° to the horizontal with the lower border of the field at the upper margin of the anus, sparing the terminal 2.0 cm of the anal canal. Figure 3 shows the computer printout of the dosimetry in the pelvis with all three portals, delivering 100-percent dose in the area of the prostate and 70-percent dose in the area of the pelvic nodes, sparing large portions of the rectum, urinary bladder, and terminal 2.0 cm of the anal canal from a high dose of radiation.

Similarly, in cases of carcinoma of the pancreas, scanning of the abdomen is done in longitudinal and transverse planes, taking the umbilicus and xyphoid as the anatomic reference points. We can then find the location of the tumor with respect to these points, measure its size in centimeters on the ultrasound picture, and, hence, mark the location and the extent of the tumor on the skin of the patient for precise radiation therapy portals. As shown in Figures 4 and 5, the size of the tumor of the head of the pancreas (marked "T") measures 6.0 cm in the longitudinal plane and 6.0 cm in the transverse plane. (Distance between the two dotted marks is 1.0 cm.) The tumor extends downward to 4.0 cm above the umbilicus (marked "U") and upward to 6.0 cm below the xyphoid (marked "X"). After marking the longitudinal dimensions of the tumor on the abdominal skin, the transverse extent is defined with respect to the midline. As shown in Figure 5, the tumor extends 4.0 cm to the right and 2.0 cm to the left of the midline, which is determined here from the center of the vertebrae (marked "V"). As the extent of the tumor is clearly defined with the markings on the abdominal skin as described herein, a radiation portal is tailored with a 2.0-cm margin around the tumor, which is 8.0X8.0 cm

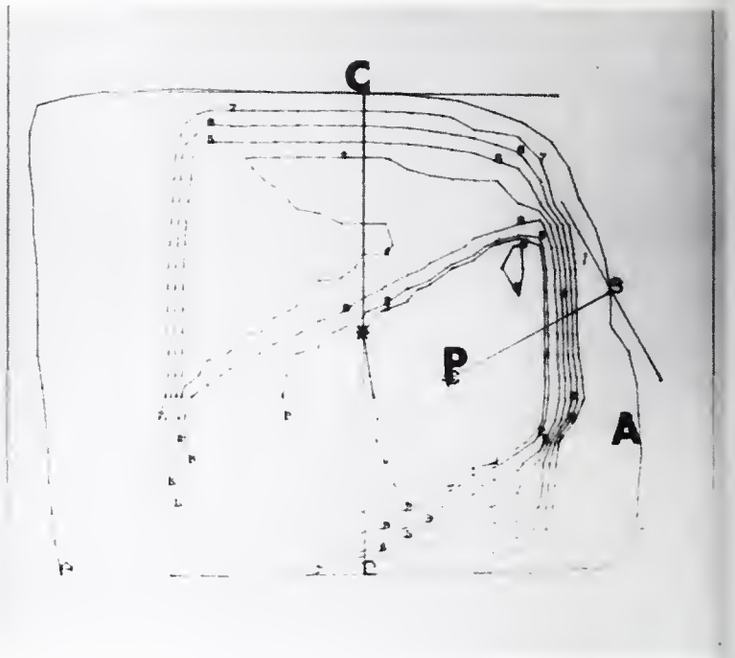


Fig. 3. Computer dosimetry printout.

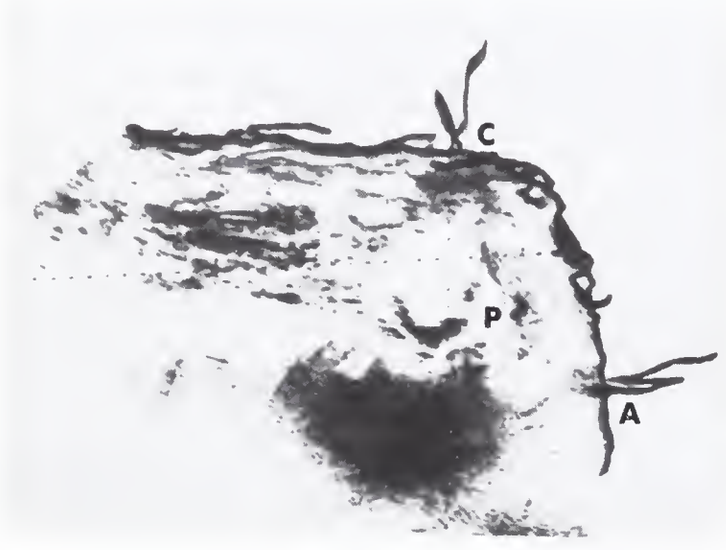


Fig. 2. Longitudinal ultrasound scan of lower abdomen and pelvis.



Fig. 4. Longitudinal ultrasound scan of abdomen.



FIG. 5. Transverse ultrasound scan of abdomen.

in this patient, as the tumor extent is 6.0X6.0 cm in transverse and longitudinal directions, respectively.

Likewise, ultrasound can be used in localizing intra-abdominal tumors for radiation therapy treatment with a small field in localized disease, sparing unnecessary radiation to the other vital organs such as the small bowel, kidneys and other organs.[6-8]

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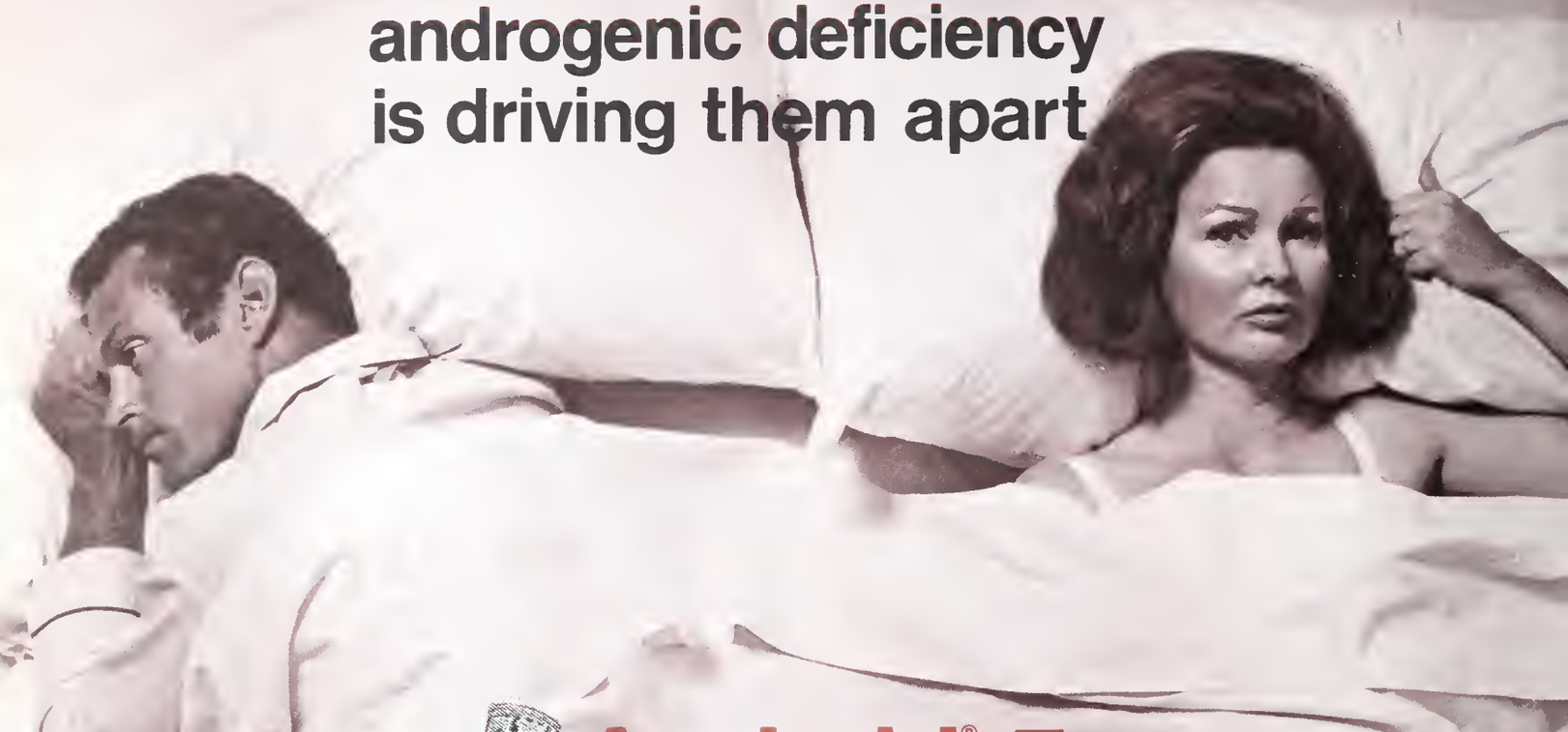
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Lesser-Known Aspects of Multiple Sclerosis

George W. Paulson, M.D.
James M. Parker, M.D.

Research into the basic mechanisms of multiple sclerosis (MS) continues to yield new information and has led to new treatment modalities. Yet today, as in the past, there is no proven method of treatment for the basic disease process.

As with most chronic diseases, the day-to-day impact of MS upon the life of the patient and the family, in turn, is influenced by social and family pressures, weather, intercurrent illness, employment, medications, and other aspects of the environment. Over and above these factors, patients frequently report troublesome physical and emotional symptoms which may or may not be accompanied by objective physical findings. Patients often are reluctant to report these because they feel that most of them must reflect emotional illness, or because these vague symptoms were interpreted as psychosomatic by a physician. Reassurance that these manifestations are really due to the multiple sclerosis itself and are not signs of mental illness can yield considerable benefit in terms of the patient's ability to cope with his disease.

This is a review of some of these less-recognized, but frequently encountered, symptoms and signs. It is based on information from 250 patients with multiple sclerosis who have been seen in the past four years.

THERE ARE MANY well-recognized features of multiple sclerosis (MS) including, in particular, remissions and exacerbations plus involvement of multiple areas of the central nervous system. This is a review of some of the lesser, atypical, or poorly recognized features of the disease. Observations are from 250 office patients seen in four years, and they serve as the basis for these comments.

Diagnosis of Multiple Sclerosis Utilization of Atypical Features

Lhermitte's Sign

Lhermitte described an "electricity" feeling across the shoulders in some patients extending down the back when the neck was flexed. This phenomenon is more likely to be produced by voluntary flexion than by involuntary rotation or flexion, perhaps because of the forceful nature of movement on command. The sensation generally subsides after repeated bending. Although not unique to multiple sclerosis, when Lhermitte's sign is reported spontaneously by a patient, it is of great diagnostic value. One of the difficult features of the phenomenon is the marked variability from patient to patient. Some patients have a tingling sensation, others a feeling of "electricity," and a few will even have what they describe as pain. Even motor phenomena can be elicited by the flexion of the neck in some patients. In most, there is extension of the sensation down the trunk; in some, it extends to the arms or into all four of the limbs. If only one upper extremity is involved, the clinician has to consider osteoarthritis or nerve root compression.

The reason for Lhermitte's sign is unknown. Presumably, a mechanical stimulation is triggered by distortion of the spinal cord during bending when there is an underlying difference in density and firmness of those portions of the cord involved by the disease. The transitory motor phenomena are atypical with actually brief, transitory spasms of the upper extremities, lasting only a few seconds and not truly typical of the so-called "tetanic spasms."

Like any other symptom in multiple sclerosis, Lhermitte's sign is likely to come on acutely during an exacerbation and then subside more gradually. Its time pattern is reminiscent of that in any other symptomatology in MS, in that it may occur insidiously over a period of several days and take weeks or months to clear. Lhermitte's sign leaves some patients with a residual discomfort but, as with all other single features of the disease, it slowly subsides. The most important feature that emphasizes the significance of Lhermitte's sign is the degree of spontaneity with which the patient describes it. In our practice, at least a quarter of the patients who develop multiple sclerosis — possibly an even higher percentage — report features of this entity at some time. Many of them have actually read about

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Submitted June 24, 1976.

Lhermitte's sign, and there may be overreporting by enthusiastic and cooperative historians. Except for MS, Lhermitte's sign is an exceedingly uncommon feature in other disorders that affect young people. Nevertheless, a similar phenomenon can occur, not only in osteoarthritis but in cervical spondylosis, cord tumors, and similar disorders.

Tetanic Spasms

"Central tetanus," or tetanic spasms, had probably been described before Matthews,[1] but his certainly is the classic article. These spasms occur in as high as 5 percent of patients with multiple sclerosis, but mostly in the later phases when diagnosis is already too obvious. We have seen one or two patients who had this phenomenon at an early phase of the illness; it can be quite striking as a complaint and equally striking when witnessed. However, since the physician seldom has an opportunity to witness this tetanic phenomenon, the complaint of the patient may be interpreted as hysterical. The spasms usually involve the upper limbs, they can involve the legs, or both legs and arms. The spasms usually are unilateral.

During a spasm, the hand suddenly becomes tight, fingers may be extended or clenched, and the massive muscle spasms slowly subside after 30 seconds or more. They come on abruptly but may be triggered by activity. Clonic or jerking movement, as with epileptic seizures, is rare. The spasms often are associated with sensory deficit on the same side and may relate to disease of the posterior roots or to a distortion between the afferent input and the motor neuron system. Tetanic spasms have been described with all types of multiple sclerosis, but they are more prominent in patients with overt spinal cord involvement.

Sensory Deficit

It is classically reported that most patients with multiple sclerosis have sensory deficits, and though numbness and tingling sensations are probably the more familiar initial complaints of most patients, much more usually can be gleaned from the description than from an examination. Although they complain about sensory disturbances, many patients with multiple sclerosis will have a normal, or almost-normal, neurologic evaluation. Such a complaint, out of proportion to the findings, must be distinguished from hysterical sensory complaints. The patient may complain only of *loss* of sensation, but more frequently complains of a *distortion*. The limb feels as if it tingles, burns, or as if there is a band around it. At times, there is a change in sensation to temperature; and things that should appear painful appear cold, or things that should feel cold, in fact, feel wet. The fingers may feel as if there was a rubber glove on, or as if the fingertips had been abraded. At times, the patient professes to be uncertain as to whether or not there is a real deficit and, especially as the symptom improves, patients appear doubtful that the sensory loss was ever actually present. The limbs are particularly likely to be involved; the location occasionally contrasts to what one might anticipate in view of the central representation of these portions of the limbs. In most central disorders, the distal areas — thumbs and hands — are more involved than the proximal limb area, but in MS, the trunk or proximal areas are often effected. At times, an isolated patch of dysesthesia is noted in the thoracic region. As in the motor system, though the sensory complaints are exceedingly common, a total deficit is rare, and a totally anesthetic limb is almost nonexistent in MS. Of course there are exceptions and, as in cases with acute, severe lesions, there can be marked deficits in levels or a partial Brown-Séquard syndrome. More usual, however, the deficits are spotty, diffuse, and shifting.

Motor

Most common of all motor deficits probably is difficulty with walking. The gait disturbance is often complex and is rarely described adequately as either ataxic or spastic. In fact, the classical multiple sclerosis gait is a combination of both. Furthermore, weakness may be present with a partial footdrop, but the weakness usually is not sufficient to account for the disturbance in gait. There may be particular difficulty with rapid turns or with sudden shifting, as well as in climbing stairs or getting around a stair landing. The combination of cerebellar and long-tract signs is exceptionally common. Indeed, in young patients seen in our office, the most likely cause for such a disability is a demyelinating process since very few processes affect widely disparate portions of the nervous system and produce such a gait disturbance.

Another interesting feature is a "flail" hand. Though the patient can grip with moderate strength when asked to do so and has sensation largely intact for pin and touch, nevertheless, the hand is not used and tends to be floppy, incoordinate, and apparently quite weak. Mild atrophy may be present. The combination of sensory deficit, motor loss, and incoordination leads to functions being disproportionately deranged when one considers only the amount of actual strength remaining.

Bladder

It is the rare patient with MS, especially the female patient, who has no bladder complaints. Urgency or retention are most common and this may be a markedly variable response with bladder control varying from month to month, being unpredictably either spastic or atonic. The most typical complaint is the feeling of the need to urinate and then, after sitting down, discovering the inability to urinate or the production of only a few drops. Burning and discomfort are unusual unless infection is present.

Sexual Feeling

There are many articles in the literature suggesting that men (over 50 percent) have some loss of potency

with MS. In some cases, loss of interest and general disability will erase any concern, but impotence is the major cause of concern for others. There may be an occasional report of painful or delayed ejaculation, but this usually clears up over a period of time. Most women who have any bladder symptomatology also have some change in sexual sensitivity. Several patients have been seen in whom this was a major source of stress in their marriage; it is important to explain this fully to the patient. For some females, frigidity implies lack of love and, actually, the patient may be reassured when she learns there is a physiologic reason for this lack of responsiveness.

Reflexes

In contrast to patients with various spinal cord diseases and to those with peripheral neuropathies, it is unusual to find one with multiple sclerosis who does not have increased reflexes rather than a decrease in the reflexes in the legs. Posterior roots or caudal cord disease would have to be involved in order to have a loss of reflexes and statistically, the more common disorder in multiple sclerosis is a more rostral involvement. In addition to hyperreflexia, asymmetry of reflexes is exceptionally common, particularly at the knees or biceps. With lesions at C5 and C6, an inverted radial reflex may be found, although often an inverted radial reflex can suggest pressure outside the cord rather than disease within it. Absence of the skin abdominal, of course, is classic in multiple sclerosis, but many early cases do not manifest this feature. Of more diagnostic significance is the dissociated skin abdominal reflex, or the absence of the skin abdominal with hyperreflexia of the rectus abdominis muscle when percussed beneath the rib cage. The deep muscle response of the rectus is increased, as with any other deep tendon reflex, whereas the skin reflex (which is dependent upon cortical centers to some degree) will be absent. Wartenberg[2] has suggested that this dissociation of skin and muscle reflexes is more indicative of a cortical spinal tract involvement than is a Babinski sign.

Eye Signs

In addition to the classic symptom of retrobulbar neuritis, with its phenomena of "the patient can't see and you can't see anything either" and of a central scotoma, many eye conditions are classical in multiple sclerosis. In a young person, intranuclear ophthalmoplegia is very suggestive of MS, but a complete intranuclear ophthalmoplegia is much rarer than a partial manifestation of this entity. Even when incomplete, possible intranuclear ophthalmoplegia should be checked repeatedly because of the high diagnostic significance when it is present. Incomplete intranuclear ophthalmoplegia is seen in at least 10 percent of patients with MS at some time during the course of the disease.

Far more prevalent than intranuclear ophthalmoplegia is a dissociation or dysmetria of eye movements. As the patient looks rapidly from side to side, the normal slight jerkiness of the movement is increased in a chaotic and irregular fashion. In approximately eight patients, we have been impressed by an associated movement not currently recorded in the literature, one not peculiar to multiple sclerosis but which has been seen more frequently in this entity than in any other condition. This is a side-to-side movement of the chin at the same time the eyes are moving from side to side. It is only one of many overflow phenomena involving the eyes and mouth.

Vestibular Systems

It seems likely that MS produces as many manifestations in the total vestibular and hearing systems as there are in the visual system. However, it is difficult to identify them, either symptomatically or by examination. Whereas blindness is quite striking, incomplete or transitory loss of hearing in one ear may not be so remarkable. Positional nystagmus is seen frequently in patients with MS, and a complaint of subjective dizziness or inner ear disease is very common indeed.

Uhthoff's Sign

It has been known for years — and utilized as a diagnostic test — that symptoms and signs of multiple sclerosis can worsen with heat (Uhthoff's sign). Less apparent is the response to fatigue and to a shift in body temperature. Patients may complain that a warm bath or exercise on a warm day will produce profound weakness or will decrease vision.

Fatigue

One of the most striking aspects of this disease, indeed, probably the single most common aspect of it, is a sense of fatigue. Patients who were previously effervescent, enthusiastic, and busy with physical activities become unable to perform their daily chores. A sense of grinding exhaustion late in the afternoon may lead to rest or the need to lie down. After simple acts such as preparing supper or going shopping, the patient may have an overwhelming need to rest. Furthermore, a lack of initiative for beginning new things is noted; this may be one of the several features that imperils domestic tranquility.

One of the striking clinical characteristics of many patients with multiple sclerosis is the family turmoil engendered by this disease. Some of the unrest has to do with lack of sexual ability, some with the emotional lability of patients, and perhaps with the failure of the patient to fulfill what the spouse considers minimal marital and domestic duties. Undoubtedly, fatigue contributes to such failing.

Variability

It is well known that MS is amazingly variable. Classically, it is described as a disease characterized by remissions and exacerbations, but one feature is not so well emphasized. Though the disease may worsen from

month to month and week to week, there are individual patients who will have marked fluctuations of shorter duration during each day. These fluctuations may last only minutes or an hour at most. The patient may be aware of numbness or tingling, but these sensations subside rapidly. Although the fluctuations can be triggered by heat, more often, the shifts are spontaneous and of uncertain etiology and can be quite brief.

MS still remains a disease of exclusion, and undue readiness to diagnose the disease is improper. The day may come, hopefully during the next generation, when the desire to diagnose the disease early is justified because definitive therapy has become available. Unfortunately, such is not the case now. Nevertheless, attention to some of these relatively less-known features of the disease may help with the diagnosis in this remarkable and distressing disorder.

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1. Matthews WB: Tonic seizures in disseminated sclerosis. *Brain* 81:193-206, 1958.
2. Wartenberg R: *The Examination of Reflexes, a Simplification.* Chicago, Yearbook, 1945.

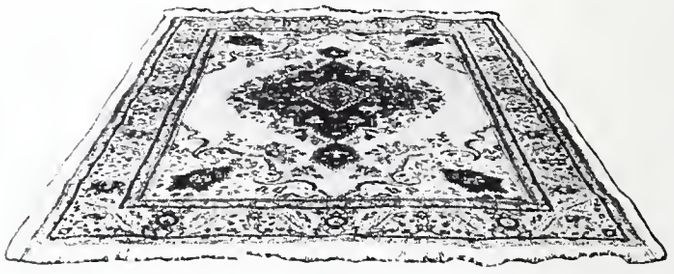
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obituaries

JASPER F. CAVA, M.D., Mingo Junction; Loyola University Stritch School of Medicine, Maywood, Illinois, 1929; age 78; died December 30, 1976; member OSMA and AMA.

WILLIAM R. DOHERTY, M.D., Montgomery, Alabama; University of Cincinnati College of Medicine, 1937; age 64; died April 8, 1975.

JOSEPH L. FRIEDMAN, M.D., Cleveland; Ohio State University College of Medicine, 1934; age 68; died December 19, 1976; member OSMA.

ROSE HERMAN, M.D., Los Angeles, California; Womens Medical College of Pennsylvania, Philadelphia, Pennsylvania, 1945; age 70; died December 13, 1976.

HERMAN HONECK, M.D., Toledo; Eclectic Medical College of Cincinnati, 1916; age 87; died December 12, 1976; member OSMA and AMA.

HARLAND HOWE, M.D., Akron; McGill University Faculty of Medicine, Montreal, Quebec, 1922; age 77; died November 29, 1976; member OSMA and AMA.

JAMES O. LUDWIG, M.D., Mansfield; University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, 1951; age 56; died December 12, 1976; member OSMA and AMA.

FRANCES PICKETT, M.D., Tucson, Arizona; Medical College of Pennsylvania, Philadelphia, Pennsylvania, 1915; age 90; died December 1, 1976; member OSMA and AMA.

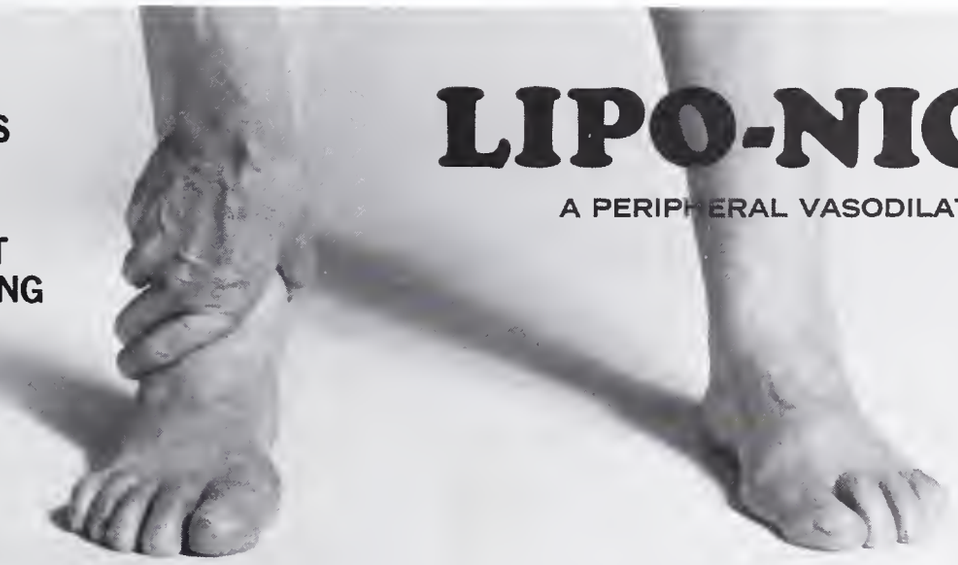
BURMAN PRESTON, M.D., Cincinnati; University of Cincinnati College of Medicine, 1929; age 75; died December, 1976; member OSMA and AMA.

WALTER H. ROEHLL, M.D., Middletown; University of Cincinnati College of Medicine, 1924; age 76; died December 16, 1976; member OSMA and AMA.

FERNAND SIEGEL, M.D., Cincinnati; Eclectic College of Cincinnati, 1939; age 65; died February 18, 1976; member OSMA.

GERALD G. WOODS, M.D., Rossford; University of Michigan Medical School, Ann Arbor, Michigan, 1933; age 70; died November 26, 1976.

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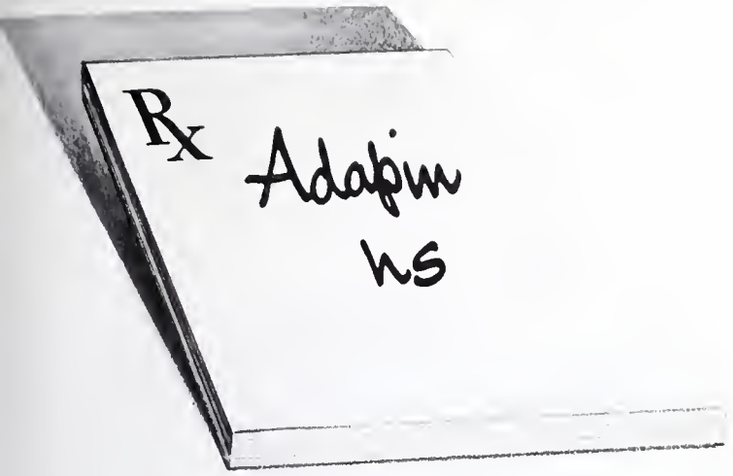
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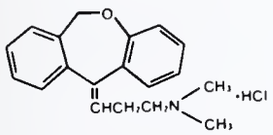
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Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride),** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin;** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

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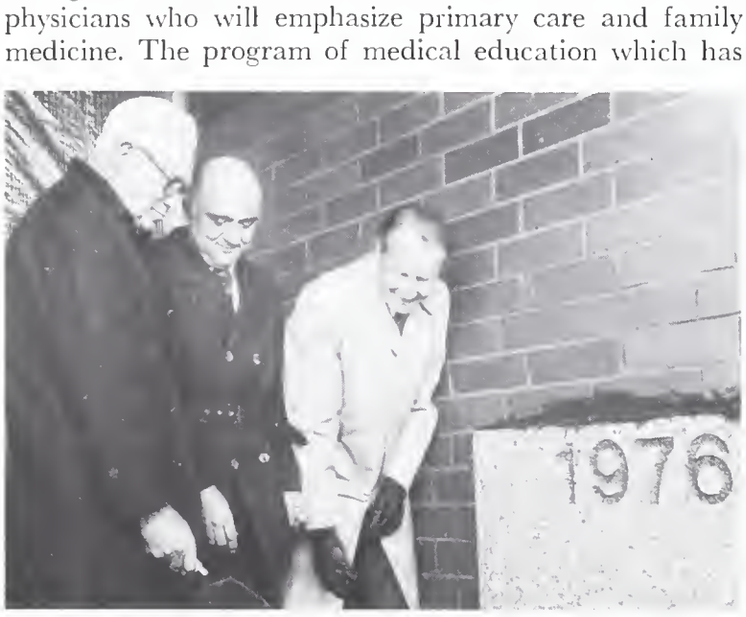
Cornerstone Ceremony at Northeastern Ohio Universities

December 1976 marked the laying of the cornerstone at the entrance to the basic medical sciences building on the campus of Northeastern Ohio Universities College of Medicine (NEUCOM), Rootstown. Participants in the ceremony included members of the Ohio General Assembly; officials of the College of Medicine; and representatives of the University of Akron, Kent State University, and Youngstown State University.

State Senator Oliver Ocasek, President Pro Tempore of the Ohio General Assembly, was the main speaker at the luncheon following the ceremony. He congratulated the faculty and staff of NEUCOM on the excellent progress being made to ready the $13 million facility for the charter class. Former State Senator Robert Stockdale placed the legislation creating the medical school in the cornerstone; and The Honorable John F. Seiberling, U.S. House of Representatives, 14th District, enclosed a bicentennial pin and letter to the openers of the box in the year 2026.

Also depositing items in the cornerstone were Stanley W. Olson, M.D., NEUCOM provost; Robert A. Liebelt, M.D., NEUCOM dean; Robert E. Tschantz, M.D., president of the NEUCOM board of trustees; E. Jay Wheeler, M.D., Ph.D., director of medical education research and curriculum development at NEUCOM.

The Ohio General Assembly created NEUCOM, acting in concert with the three area universities, to train physicians who will emphasize primary care and family medicine. The program of medical education which has been developed encompasses six years and leads to a combined B.S./M.D. degree program. Students successfully completing the program will receive a bachelor's degree from one of the participating universities and a medical degree from the College of Medicine. Those currently enrolled in the charter class are expected to enter the third or basic medical sciences year at Rootstown in July 1977, with graduation in 1981.



Left to right: Robert E. Tschantz, M.D.; Robert A. Liebelt, M.D., Ph.D.; and Stanley W. Olson, M.D.; add mortar at the cornerstone-laying ceremony at Northeastern Ohio Universities College of Medicine. (Photo by Douglas Moore, Kent State.)



Stanley W. Olson, M.D., observes as E. Jay Wheeler, M.D., Ph.D., places items in the cornerstone box of the NEUCOM basic medical sciences building. (Photo by Lewis Tobias.)

Ohio State Professor Receives American Heart Association Award

James V. Warren, M.D., Professor of Medicine and Chairman of the Department of Internal Medicine at The Ohio State University College of Medicine, received the American Heart Association's 1976 James B. Herrick Award for outstanding achievement in clinical cardiology. The award was presented to Dr. Warren during the Heart Association's Annual Meeting held in November.

Dr. Warren was cited for his research accomplishments, his teaching skill, and his medical leadership. The Association noted that, at a time when clinical cardiac catheterization had its inception, Dr. Warren was one of the first to perceive its potential in the investigation of normal and abnormal circulatory response.

Perhaps his most notable contribution to the scientific literature, the Heart Association said, was his observation that the development of edema and the increase in plasma volume in conjestive heart failure occurred prior to the development of an elevation in venous pressure. This led to the concept of "forward heart failure."

The Association also stressed Dr. Warren's contribution to the practice of cardiology through his early emphasis on the immediate management of patients with

(continued on page 83)

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School Highlights *(continued)*

acute myocardial infarction. He was among the first to conceive the mobile coronary care approach to patient management and establish the first such unit in the United States in Ohio.

In presenting the award, the American Heart Association said of Dr. Warren: "(He) has done many things first and has done all things well. His publications began enriching the body of scientific knowledge in 1941 and his brilliant investigations continue to make an important impact on cardiology. Over that 35-year span, he has been in the forefront of acquiring and disseminating new knowledge not only concerning basic mechanisms of disease but also in improving the manner in which cardiovascular disease could be managed. And he has passed this knowledge along through a teaching style of such distinction that it illuminated the path for many of his trainees who now rank among today's leaders in cardiology."

Federal Grant to Cincinnati Department of Physical Medicine

Continuing development in physical medicine and rehabilitation at the University of Cincinnati Medical Center is being supported by a $51,512 grant from the United States Office of Rehabilitation Services. The Department of Physical Medicine and Rehabilitation was established in 1969. It has a 15-bed, adult rehabilitation unit at General Hospital and is responsible for physical medicine and rehabilitation services at Holmes Hospital, Children's Hospital Medical Center, and Cincinnati Veterans Administration Hospital. In addition, members of the department's clinical faculty head physical medicine and rehabilitation programs at Bethesda, Christ, Drake, Good Samaritan, and Jewish Hospitals in Cincinnati.

Randall L. Braddom, M.D., Associate Professor and Director of the Department of Physical Medicine and Rehabilitation in the College of Medicine, indicated that the grant will fund the following: (1) effective teaching of rehabilitation medicine to undergraduate medical students to give them the capacity of caring for physically disabled patients; (2) establishment of a residency program to provide disabled medical consumers with physicians capable of and interested in handling their complicated rehabilitation problems; and (3) training of allied health professionals for the rehabilitation team.

Funding for Case Genetics Center

Development of the Case Western Reserve Genetics Center for Northern Ohio will be made possible due to a $350,000 grant from the Cleveland Foundation to the Case Western Reserve University School of Medicine (CWRU). The award, one of the largest to be made by the foundation in recent years, will provide for expansions of genetics services in the area which includes Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, and Summit counties. The goal of the center's program is to lower the incidence in the region of genetic diseases, which presently affect 1 in 20 individuals and account for one in four hospital admissions and one in five health care dollars.

Need for a regional program is seen in the fact that of 62,500 births annually in the seven-county area, approximately 3,100 infants may have genetic disorders; but only one in six affected families are currently being seen for genetic diagnosis, treatment, or counseling in the present CWRU genetics program.

The regional center, which will be directed by W. Angus Muir, M.D., will involve coordination and expansion of the CWRU Heredity Clinics, located at University Hospitals and Cleveland Metropolitan General Hospital. These institutions have a case load of some 500 families a year, largely from Cuyahoga County.

An outreach program will establish genetic counseling units throughout the area, and an extensive professional and public educational program will be launched. At the outreach clinics, genetic associates trained at the center will be available to take "family trees" from couples with a history of suspected genetic disorders and will forward them to the center for review. A team of CWRU genetic specialists will then travel to the outreach clinic to counsel patients and their families.

Physicians in the region will have ready access to the sophisticated laboratory facilities at the center and will be involved in the follow-up care of their patients.

NEUCOM Library Receives Grant

Another grant of $100,000 to equip the medical library of the developing Northeastern Ohio Universities College of Medicine has been received from the Louis D. Beaumont Foundation of Cleveland. The Foundation was established by Beaumont, a brother-in-law of David May who founded the May Company. The fund is intended to make charitable and civic donations, chiefly in cities where the May Company has stores.

The grant will be used to purchase scientific monographs and journals as well as audiovisual equipment to encourage self-study by the medical students of the College of Medicine.

Russians Visit Cincinnati's Environmental Health Institute

Four Soviet scientists recently completed a visit to the University of Cincinnati Medical Center's Institute of Enviromental Health for consultations about scientific problems and issues of mutual interest. Dr. Raymond R. Suskind, director of the institute and of the College of Medicine's Department of Environmental Health, explained that the meetings dealt especially with collaborative efforts in environmental health between University of Cincinnati scientists and scientists in the Soviet Union.

This is the fourth team of Soviet scientists to visit the University of Cincinnati institute since the U.S. and the Soviet Union signed an agreement for collaborative research in environmental health in 1972.

Pharmacology Today . . .

Drug Therapy of Parkinsonism Dopaminergic Drugs

Joseph R. Bianchine, M.D., Ph.D.

Editor's Note: This is the first article dealing with pharmacology for the practicing physician. Dr. Bianchine will act as coordinator of the series, which will feature input from the departments of pharmacology at all the medical schools in Ohio. *The Journal* appreciates this cooperation.

PARKINSON'S DISEASE usually appears insidiously in the latter decades of life and produces a slowly progressive disability in movement. The disease usually manifests four major clinical features: tremor, bradykinesia, rigidity, and disturbance of posture.

The striatal tracts, important for the smooth control of voluntary movements, normally contain balanced (and opposed) dopaminergic and cholinergic components. There is a marked absolute deficiency in the dopaminergic component of the basal ganglia in parkinsonism. Consequently, the theoretic goal of treatment in this disorder is to balance striatal activity by reducing cholinergic activity or enhancing dopaminergic function with anticholinergic drugs and dopaminergic drugs, respectively. Often these two drug classes are combined effectively.

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Levodopa

Levodopa, the immediate metabolic precursor to dopamine, passes through the blood-brain barrier into striatal tissue, where it is decarboxylated to dopamine, the deficient neurotransmitter. Thus, levodopa replenishes depleted stores of dopamine.

Approximately 75 percent of patients with parkinsonism respond at least reasonably well to levodopa. Essentially all symptoms of parkinsonism can respond to levodopa. However, rigidity and bradykinesia generally respond better and more promptly than tremor. There are day-to-day and within-day variations in the apparent effectiveness of levodopa. These variations, sometimes termed the "on-off" phenomenon, can be minimized by careful individualization of treatment for each patient.

Levodopa is rapidly absorbed from the small bowel and peaks in serum at one or two hours after an oral dose. Side effects of special concern include:

Nausea, vomiting and anorexia. These symptoms, most pronounced during the initiation of levodopa treatment, are controlled by concurrent administration of food or by lowering the dosage administered. Although phenothiazines are highly effective antiemetics, they should not be used for the control of nausea here because they negate the antiparkinsonism effect of levodopa.

Abnormal involuntary movements. These movements appear in approximately half the patients, usually within two months of initiation of treatment. They are variable in type and include faciolingual tics, head bobbing and various rocking movements of the arms, legs or trunk. They are abolished by lowering the dose of dopa administered, but this reduces the efficacy of levodopa as well.

Behavioral side effects, cardiac dysrhythmias and orthostatic hypotension also may occur.

Pharmacologic doses of pyridoxine (5 mg or more) enhance the extracerebral metabolism of levodopa. Consequently, when administered with levodopa, pyridoxine may completely reverse its therapeutic effect.

Reserpine and Phenothiazine

Chronic administration of the drugs can cause parkinsonism by depleting striatal dopamine. This possible etiologic factor should be considered in every newly diagnosed case of parkinsonism. If the exposure to either compound was short-lived, it is likely that withdrawal alone will cause disappearance of parkinsonism.

Clinical Use. There are two phases of treatment with levodopa. An initial "induction" phase lasting several

weeks were followed by a long-term "maintenance" phase. During the "induction" phase, the daily dosage of levodopa is increased slowly to minimize the likelihood of side effects. The initial levodopa dose of 250 mg, three times daily by mouth after meals, is increased to two to four gm daily in divided doses over a period of six to eight weeks. One critical factor in successful therapy during this phase is the careful and slow titration of dosage for each patient. Too rapid an increase in dosage generally results in the appearance of excessive side effects.

A "maintenance" phase follows during which the full benefits of levodopa treatment become apparent. Attempts to remove all symptoms of parkinsonism with levodopa usually require dosages that cause unacceptable side effects.

"Day-to-day" and even "within-day" variations in severity of symptoms are characteristic features of parkinsonism. Levodopa has greatly increased their complexity and importance. These swings may occur many times a day and often with startling rapidity. Many important variables contribute to this annoying, fluctuating disability. Inhibition of dopa decarboxylase may help dampen these fluctuations.

Dopa Decarboxylase Inhibitors

Concurrent administration of levodopa with a dopa decarboxylase inhibitor (carbidopa) diminishes the decarboxylation of levodopa in peripheral tissues. This allows a greater portion of levodopa to reach receptor sites in the basal ganglia. Carbidopa is available as combination tablets with levodopa (Sinemet®)* in a fixed ratio by weight (1:10). Generally, therapy is initiated with 400 mg of levodopa (40 mg of carbidopa) daily in divided doses. If more levodopa effect is needed, the combination dose can be increased progressively to a daily maximum of about 1500 mg of levodopa (150 mg of carbidopa). For patients treated previously with levodopa alone, levodopa treatment must be withheld overnight before initiation of combined levodopa-carbidopa.

The clinical advantages of giving this levodopa/carbidopa treatment over levodopa alone include diminution of nausea and vomiting, while enhancing the speed of onset of therapeutic response. The frequency and intensity of within-day variations in clinical status are reduced by the action of carbidopa. The total daily dose of levodopa is decreased by approximately 75 percent. However, dopa decarboxylase inhibitors do not resolve all problems with levodopa treatment. For example, abnormal involuntary movements and various mental effects are unaffected by carbidopa.

*Merck Sharp & Dohme

Dr. Bianchine, Columbus, Chairman and Professor, Department of Pharmacology, and Professor, Department of Medicine, The Ohio State University College of Medicine.

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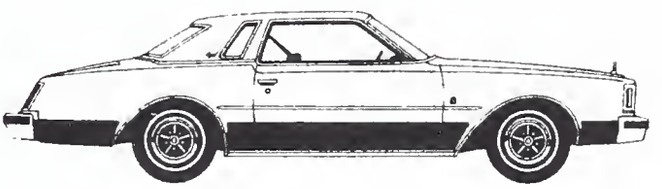
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CLINICAL NEUROSCIENCES CONFERENCE: Each Thursday, September-June; Department of Neurosciences, Medical College of Ohio at Toledo; 2 credit hours; contact: Walter Lewis Olson, M.D., Dept. of Neurosciences, Medical College of Ohio, P. O. Box 6190, Toledo 43614, phone: 419/381-3544.

Single Course Offerings

February 1977

NORMAL AGING-CREATIVE INTERVENTION: February 14-18; Stouffer Dayton Plaza, 5th & Jefferson St., Dayton; sponsor: Postgraduate Medicine, Department of Medicine and Community Medicine of Wright State University School of Medicine; cosponsor: VA, Central State University, and Scripps Foundation of Miami University; 24 credit hours; fee: $195; contact: John C. Barton, Ph.D., Wright State University, Department PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

PERITONITIS (New Look at): February 15, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 2 credit hours; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

EAR, NOSE AND THROAT PROBLEMS (Practical Management of): February 16; Fawcett Center, 2400 Olentangy River Road, Columbus; sponsor: Ohio State University College of Medicine Center for Continuing Medical Education; 5 credit hours; fee: $45; contact: OSU College of Medicine, Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. 10th Ave., Columbus 43210, phone: 614/422-4985.

COMPUTED TOMOGRAPHY OF THE HEAD AND BODY: February 16-17; Bunts Auditorium, Cleveland Clinic Educational Foundation; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $175 ($100 residents-interns); contact: Rosalind Presby, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: February 22, 7:30 AM; Riverside Methodist Hospital, Columbus, sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NEOPLASIA LYMPHADENOPATHY: February 22, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CURRENT TOPICS IN CLINICAL MICROBIOLOGY: February 23-24; Cleveland Clinic Foundation; sponsor: Cleveland Clinic Educational Foundation; cosponsor: American Medical Association; 12 credit hours; fee: $80 ($40 residents); contact: Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

March 1977

CONTINUING MEDICAL EDUCATION CONFERENCE: March 5 and 19; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Blvd., Springfield 45501, phone: 513/399-7121, ext. 341.

CONTINUING EDUCATION PROGRAM IN NUCLEAR MEDICINE FOR PHYSICIANS: March 7-11; May 9-13; July 11-15; November 14-18; Hillcrest Hospital/Nuclear Medicine Institute, Cleveland; sponsor: Nuclear Medicine Institute; cosponsor: Hillcrest Hospital; 40 credit hours; fee: $100; total tuition including registration fee: $500 ($200 residents); contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

DIAGNOSIS OF GALLBLADDER DISEASE: March 8, 8:15 PM; Steubenville Country Club; sponsor: Fort Steuben Academy of Medicine; 1 credit hour; contact: B. B. Greenhouse, M.D., Steubenville, Program Chairman.

MEDICAL SURGICAL GRANDROUNDS (Larry Carey, M.D., speaker): March 10, 12:30 PM; Community MediCenter Hospitals, Marion; sponsor: Community MediCenter Hospitals; 1 credit hour; contact Carol McNamara, 614/382-8251, extension 253.

ADVANCES IN JOINT SURGERY: March 10-11; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; cosponsor: American Medical Association; 13 credit hours; fee: $125 ($65 residents and interns); contact: Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

MEDICAL PROGRESS AND ITS RELATIONSHIP TO DENTISTRY: March 16-17; Bunts Auditorium, Cleveland Clinic Educational Foundation, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 10 credit hours; fee: $50 ($25 resident); contact: Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

SYMPOSIUM ON APPROACHES TO PAIN: March 19-20; Stouffer's Dayton Plaza Hotel, Dayton; sponsor: Wright State University School of Medicine; cosponsor: Dept. of Postgraduate Medicine and Mercy Medical Center, Springfield; 11 credit hours; fee: $75; contact: Arlene Polster, Program Coordinator, Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/429-3200, ext. 376.

12TH ANNUAL CANCER SYMPOSIUM: March 23-24; Akron City Hospital, Akron; sponsor: Akron City Hospital; 10½ credit hours; fee: $50 ($10 students); contact: Debbie Harwell, Akron City Hospital, 525 E. Market St., Akron 44309, phone: 216/375-3202.

THE 1977 SEMINAR ON BREAST DISEASES: March 26; Cleveland Museum of Natural History, Wade Oval, University Circle; sponsor: Huron Road Hospital; 6 credit hours; fee: $50 ($25 residents); contact: Department of Medical Education, Huron Road Hospital, 13951 Terrace Road, Cleveland 44112, phone: 216/851-7000, ext. 368.

TEACHING AND YOUR PRACTICE: March 26-27; Marriott Inn, Columbus; sponsor: Ohio Academy of Family Physicians; 8¾ credit hours; fee: $50 ($25 AAFP residents); contact: Ohio Academy of Family Physicians, 4075 North High St., Columbus 43214, phone: 614/267-7867.

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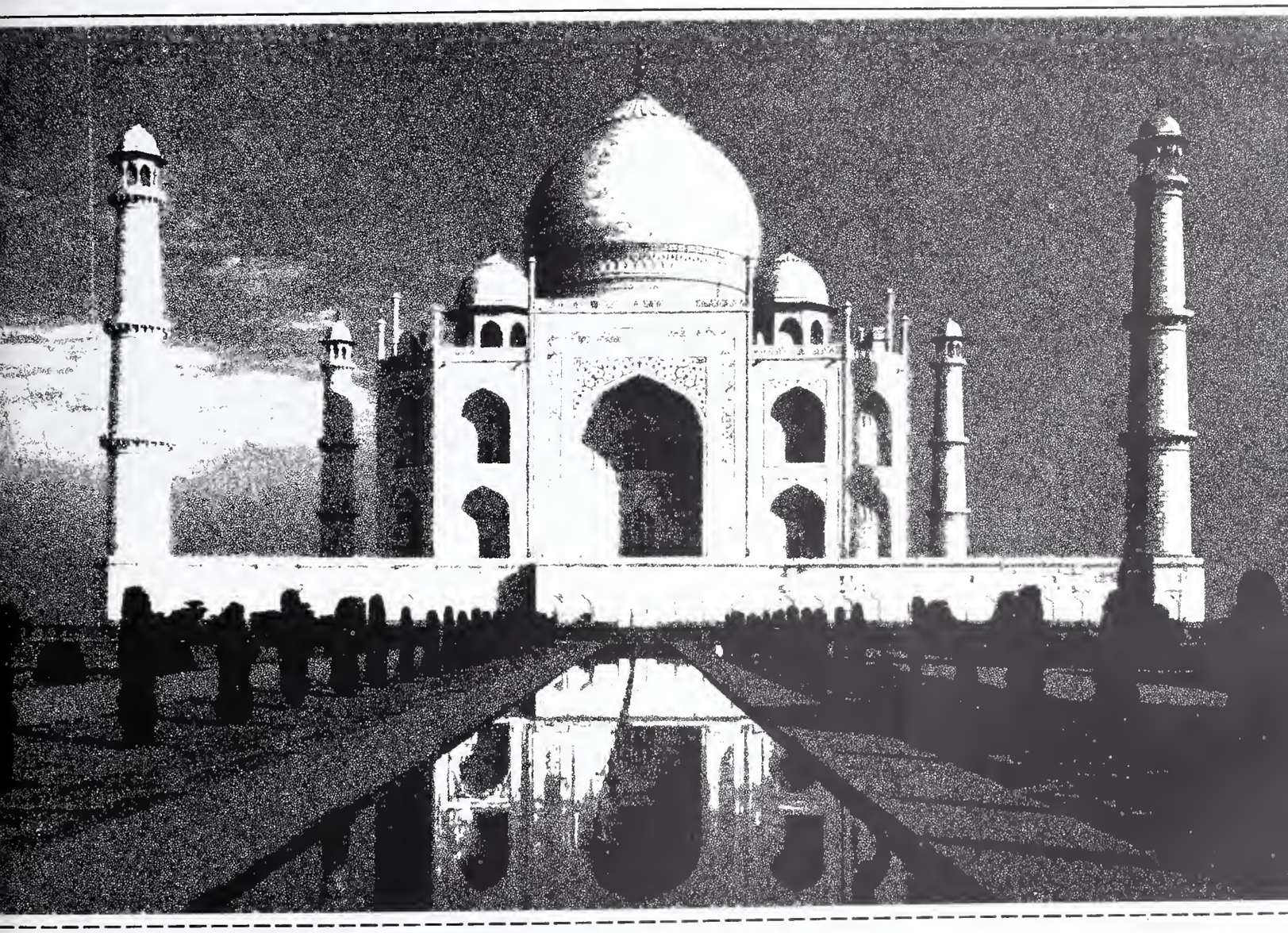
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Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

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Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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OSMA Committee on Maternal and Neonatal Health Update

Anthony J. Ruppersberg, Jr., M.D., Chairman

The National Center for Health Statistics reports: "Three quarters of the infant deaths in the United States during 1975 occurred during the neonatal period."

All too frequently, when the mother is a *high-risk,* obstetric patient, the unborn fetus may be in serious jeopardy even before it is born! After 21 years of research into causes and prevention of maternal deaths in Ohio, the OSMA Committee on Maternal and Neonatal Health now amplifies its program to collaborate in the prevention of neonatal mortality and to protect the "high-risk baby."

During its annual meeting, January 22-23, 1966, the Committee developed a program involving "medically avoidable maternal deaths." Obstetric patients having kidney disease, diabetes, cardiac hypertensive disease, and other complications were to be identified as *high-risk* obstetric patients to receive "intensive" prenatal care.

The project progressed as an educational device; interest on the part of physicians, nurses, and the lay public grew from year to year. The "high-risk" project focusing on the mother was described and evaluated in various articles in *The Journal* (June 1966 and Sept. 1968).

Members of the Committee personally reviewed 1,229 cases and affixed the newer "high-risk" designation to each of them for the IBM data-processing system. Relationship between the high-risk category and the cause of death was clearly established in every case.

The "high-risk" conditions were promptly inserted in the next revision of *Guiding Principles for Obstetric Care.*

In a very short time, the high-risk condition in the mother was further correlated with the condition and the outcome of the baby. In so far as it could be traced, the impact upon "child outcome" was established and the results published in *The Ohio State Medical Journal.*

In January 1976, the official name of the OSMA Committee on Maternal Health was changed by adding ". . . . and Neonatal Health." A subcommittee on neonatal and perinatal problems was duly appointed and, after two formal meetings, it has established its objectives and goals. Close coordination with the Maternal and Child Health Division of the Ohio Department of Health is maintained. Functions are interrelated with those of the Ohio Perinatal Club, "Action for Newborns," and particularly the Franklin County Perinatal Program under the leadership of Drs. Fred P. Zuspan and Leandro Cordero. This particular program advocates education in the use of *modern* methods to diagnose and manage problems potential in the "high-risk fetus." These include determination of urinary estriols, oxytocic challenge test (OCT), sonography, amniocentesis, cytogenics, etc.

The first survey of perinatal health and deaths in an Ohio county for six consecutive years will appear in *The Journal* ("Maternal Health in Ohio") in the March 1977 issue. The findings and encouraging results of this program can be a stimulus for a similar project in other metropolitan areas of Ohio.

Thus, a well-organized, cooperative movement to *reduce* neonatal mortality and *produce* a healthier baby is in action in Ohio.

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News

OSMA House of Delegates Resolution Deadline Approaching

Delegates to the OSMA and county medical societies who plan to submit resolutions for consideration by the House of Delegates at the 1977 Annual Meeting should be guided by Chapter 4, Section 8, of the OSMA Bylaws entitled "Resolutions," which reads as follows:

Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least 60 days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

In accordance with this Section, resolutions must be submitted no later than March 16, 1977, for consideration at the May 1977 meeting of the House of Delegates.

Nominations for President-Elect Must Be Received by March 16

Attention is called to provisions in the Bylaws of the OSMA pertaining to the nomination and election of the president-elect at the OSMA Annual Meeting. The president-elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 14-18, 1977.

Nominations for president-elect are to be made 60 days in advance of the meeting, and information on nominations will be published in the April 1977 issue of *The Journal*. The only exceptions would exist if these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 16, 1977.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect," which reads as follows:

Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least 60 days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal.

Category I Course on Television

Did you miss the television documentary tracing clinical depression as recognized and treated from ancient times through the most current methods of diagnosis? If so, you can catch the second half during the first two weeks in March. These two television films are portions of a five-part medical education course, designed for primary care physicians, on the history and diagnosis of and current concepts in clinical depression. The educational program, entitled "A Course on Clinical Depression," is sponsored by the Department of Psychiatry of the University of Pennsylvania under a grant from Pfizer Laboratories Division, Pfizer, Inc.

The entire course is approved for up to nine credit hours in Category I of the AMA Physician's Recognition Award. The second telecast, to be broadcast in March, is titled "Clinical Depression: Current Concepts of Diagnosis." It summarizes contemporary approaches to the diagnosis of depression and looks at present research that may contribute to the development of future therapies.

Suit Arising From Radiation Treatment Dismissed in Illinois

A malpractice suit citing radiation treatment given at Michael Reese Hospital and Medical Center was dismissed December 9, 1976 by an Illinois circuit court judge. In his decision, the judge ruled on the first of 40 malpractice suits filed against the Chicago hospital by patients who had received x-ray treatment of the face and neck 15 to 35 years ago. In 1973, an increased incidence of thyroid cancer was discovered among persons who had received such treatment. At the time the treatments were given, however, they were considered a standard, safe, and effective treatment for acne and chronic swelling of the tonsils, adenoids, and thymus gland.

The judge said that the plaintiff failed to produce an expert medical witness who would testify that use of the treatment was medically negligent at the time it was performed. In addition, the judge noted that the suit's filing date exceeded the statute of limitations, which requires plaintiffs to file suit within two years after becoming aware of the alleged negligence.

(continued on page 100)



1977 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1977 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus, Ohio. Exhibit Days and Times will be as follows: Monday, May 16 — 12 Noon - 4:30 PM; Tuesday, May 17 — 9 AM - 4:30 PM; and Wednesday, May 18 — 9 AM - 3 PM.

Mail applications to the attention of John E. Albers, M.D., Chairman, Committee on Scientific Work, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1977 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 16, 17, and 18

___I am interested in receiving an application and details regarding space for a scientific exhibit at the 1977 OSMA Annual Meeting. Please send to:

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comments

Peer Review

The subject of peer review has been forcefully brought to virtually every physician's attention in the past several years, primarily due to the Professional Standards Review Program (PSRO) legislated in the Social Security Amendments of 1972. Many physicians would like to see the whole idea go away. Unfortunately, in the realities of American society 1976, this is not likely to occur.

Many physicians, recognizing this reality, have risen to the challenge and are demonstrating leadership. They are giving direction to a government-legislated program so that it embodies the time-honored concepts of peer review— concepts that enhance the quality of health care.

Concerned physicians recognize that government-legislated peer review could be misused as a technique of fiscal control, and they are determined that the program will be for quality evaluation. Many knowledgeable physicians accept the fundamental that maximum quality care inherently encompasses responsible fiscal concern.

They recognize that informed-physician direction is mandatory to prevent a deterioration of care that is inherent in a government-edicted, fiscally oriented program.

To those so concerned, peer review is a challenge to demonstrate that a free medical community can examine its performance, can learn from its self-examination, and can adequately document that good, effective, and efficient care is being rendered.

Time-tested and time-honored concepts of peer review must be integrated into a government PSRO program if it is to have validity. It seems pertinent then to reexamine the accepted Webster definition of peer review. The definition of peer review comes from a composite of the respective definitions of peer and review. Peer is a person who is equal to another in abilities, qualifications, etc., and review is a formal or official inspection.

As applied to medicine, these terms relate to a physician or physicians of similar training and experience reviewing another physician's performance and rendering a value judgment of the quality of care he has provided. Therefore, while lay personnel and physician administrators are qualified to collect data, they are not equipped to conduct a review of the process of care for the elements of quality.

The goal of peer review is to upgrade the quality of medical care. Quality care is defined as a scientific approach to the establishment of a correct diagnosis and institution of appropriate therapy and management designed to satisfy the overall needs of the patient. It should be readily available, efficiently rendered, and properly documented.

Lest there is any misunderstanding, let it be emphatically repeated that the purpose of peer review is to examine the evidence and render valid medical opinions. It is not a technique to apply punitive measures.

As we see peer review evolving in this country, with much impetus fostered by government (PSRO legislation) and consumerism, it is changing from a review of a single problem case as presented by a disgruntled patient or a third party (Medicare carrier, Workmen's Compensation, or insurance company) to a review of each physician's total practice pattern. As the developing technology demonstrates, it is apparent that certain statistics can be generated which must be intelligently analyzed by the appropriate local peer review.

The analysis, evaluation, and recommended appropriate action must then be carried out by the peer review organizations. The educational aspect must be continually emphasized. Physician acceptance will depend on the manner in which peer review is managed— educational versus punitive.

There must be continued efforts to foster physician self-examination and to develop attitudes avoiding a feeling on the part of the physician that his creativity and originality are jeopardized by his peer guidance. In addition, when approached as an educational effort, the peer review mechanism will avoid the pitfall of being a defense mechanism protecting certain physicians by their peers. Such actions in the past have led to questioning of the validity of certain peer review processes.

Techniques to evaluate given problems or particular physician practice patterns are currently evolutionary. Quality assessment is a very elusive concept; however, there are certain concepts that are currently being addressed and are subject to analysis.

Among these is the concept that a peer review system needs to develop techniques to sort out physicians in terms of what they actually do competently for patients as opposed to evaluating a physician in terms of how he trained, what specialty societies he joined, or how well he fared on qualifying examinations. In essence, this is evaluation by "assessment of performance."

Assessment of performance requires techniques to develop criteria on (1) how well a given phyician can identify patients' problems, and (2) how well he can organize the problems for a solution.

Such criteria will need to be developed to permit assessment of problem identification by a physician. For instance, aspects of how a physician approaches problem identification are (1) his strategy and completeness of search for data applicable to the problem; (2) the depth of his theoretical understanding: (3) the delicacy of the analytical capacity; (4) his ability to organize his data and his understanding to permit him to make sound therapeutic decisions, and (5) his ability to sustain quality and energy in his daily attack on all types of patient problems.

(continued on page 96)

Comments *(continued)*

To convert these concepts to an objective data base is an extremely difficult job and certainly points out that only local peers, knowledgeable in all these areas, can appropriately render valid opinions in this difficult endeavor.

Obviously, systematic review of any given physician's practice pattern by the peer review organization cannot be done by a manual technique. This would require untold physician man-hours that would make the process costly and prohibitive. Techniques to assist peer review are becoming available by utilizing appropriate frequency of occurrence of physician procedures as developed by computer capability. The appropriate frequency data can be generated and supplied to the peer review mechanism for deliberation and objective evaluation. Statistically valid sampling can be identified to permit the peer review mechanism to evaluate medical records in depth with a minimum of expended physician time. The educational aspect of peer review is thus enhanced by presenting statistically valid data that minimizes subjectivity and maximizes objectivity.

Physician encounter forms are readily adapted to this type of study and offer an economical but valid statistical base of practice patterns. The encounter form itemizes virtually all procedures performed by a physician which then facilitates converting to a computer system that will identify frequencies of procedures in relation to statistical norms. Here, again, it becomes mandatory to reiterate that the statistical data supplied is only a screening tool to permit the peer review committee to render a valid opinion.

The peer review organization, in turn must demonstrate accountability and be ready to demonstrate that appropriate review and educational and/or remedial action were implemented. This documentation does not mean to identify physicians and patient records outside of the peer review process but it does not mean that an accountability of activity must be available for those nonprofessionals with legitimate interests (foundation, third parties, and patients).

This type of accountability implies an ongoing descriptive report of (1) source and type of data base; (2) frequency of review; (3) extent of review (ie, all physicians reviewed or only selected problems); (4) whether review is concurrent, retrospective, or both; and (5) the composition of the peer review committee.

In conclusion, it is hoped that this discussion can generate genuine interest, understanding, and cooperation by physicians in the peer review process in order to continue medicine's great heritage of self-examination, innovation, and basic and primary concern for the quality of health care.

Paul S. Metzger, M.D., Columbus
President, Ohio Society of Internal Medicine

Doctors, Lawyers, and Oranges

Part of the problem between doctors and lawyers is that they don't speak the same language. For example, when a doctor gives somebody an orange he says, "Here's an orange for you." But when a lawyer does the same thing he says, "Know all men by these presents that I hereby give, grant, bargain, sell, release, convey, transfer, and quitclaim all my right, title, interest benefit, and use whatever in, of, and concerning this chattel, otherwise known as an orange, or citrus orantium, together with all appurtenances thereto of skin, pulp, pip, rind, seeds, and juice, to have and to hold the said orange together with its skin, pulp, rind, seeds, and juice for his own use and behoof, to himself and his heirs in fee simple forever, free from all liens, encumbrances, easements, limitations, restraints, or conditions whatsoever, any and all prior deeds, transfers or other documents whatsoever, now or anywhere made to the contrary notwithstanding, with full power to bite, cut, suck, or otherwise eat the said orange or to give away the same, with or without its skin, pulp, pip, rind, seeds, or juice."

Reprinted from *The New York County Medical Society Newsletter,* Volume 4, Number 8, August 1976.)

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Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
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in coughs of colds, "flu" and u.r.i.— clear the tract with the famous Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

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Non narcotic for 6-8-hour cough control

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Decongests nasal passages and sinus openings as it helps relieve coughs

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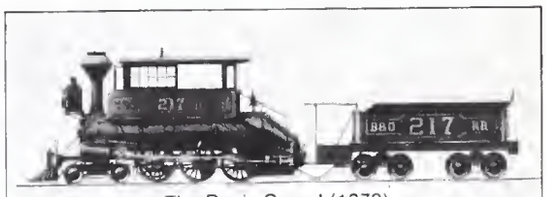
Decongestant action helps control cough and clear stuffy noses and sinuses. Non narcotic.

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All Robitussin formulations available on your Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

◀ *OUR PHOTO: Norfolk & Western Branch Train No. 202 west bound near Alvarado, Va (Oct., 1956). This line reaches the highest point of any railroad East of the Rockies (elevation 3,577 ft.) with a minimum grade of 3%. It crosses 108 bridges, some 700 ft. long! Photo by O. Winston Link.*

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☐ Send latest information on Paget's Disease of Bone.
☐ Have your representative call on me.

Dr. _____

Address _____

City _____ State _____ Zip _____

News

(continued from page 92)

When the potential danger was discovered, Michael Reese and other hospitals made vigorous efforts to locate the former patients and reexamine them. Studies indicate that as many as 71,000 persons may have received such treatments between the 1940s and late 1960s in hospitals in the Chicago area alone.

American Hospital Association Proposes Exam Equivalent For Foreign Medical Graduates

The American Hospital Association (AHA) is proposing a temporary alternative to part of a new law threatening the supply of foreign medical graduates in U.S. hospitals, especially public-general hospitals in urban areas. In communications to government officials, the AHA is urging recognition of the Educational Commission for Foreign Medical Graduates (ECFMG) examination as a temporary equivalent to the exam conducted by the National Board of Medical Examiners (NBME).

The ECFMG exam should serve as an equivalent exam until the NBME exam is offered abroad, according to the AHA. The ECFMG exam is offered outside the United States and, in the past, has served as an acceptable equivalent, the AHA contends.

Signed into law October 13, 1976, the Health Professions Educational Assistance Act, P.L. 94-484, requires that FMGs entering the country after January 1, 1977, must pass parts 1 and 2 of the NBME exam. This test, however, is not offered outside the United States; and FMGs cannot obtain visas to enter the country for the purpose of receiving medical training unless they have passed the test.

Disability Plan Enrollment Period

An enrollment period lasting until February 28, 1977, has been announced for the OSMA Disability Income Protection Plan. The OSMA cosponsors this plan with many local medical societies. OSMA members may find it more liberal than other plans in so far as the amount of income that may be insured. This plan may also be used to supplement present coverages.

The plan administrator, Turner and Shepard, Inc., has mailed complete information to all OSMA members. Any member under age 56 years may apply, with all applications subject to the approval by the insurance company. Weekly benefits will continue until age 65 years if an enrollee is disabled by sickness, or for lifetime if disabled by an accident.

Correction

The Journal wishes to correct an error in the list of Ohio State Senators appearing on page 52 of the January 1977 issue. Senator Michael Schwarzwalder of the 16th District is a Democrat not a Republican as listed.

MAKE YOUR HOTEL RESERVATIONS
for the
1977 OSMA Annual Meeting
COLUMBUS, OHIO — MAY 14-18

Sheraton-Columbus Motor Hotel
50 North Third Street
(OSMA Headquarters)

Singles	$30.00
Doubles	$37.00
Suites	$78.00

Neil House Motor Hotel
41 South High Street
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Singles	$24.00
Doubles	$30.00
Twins	$32.00
Suites	$65.00 - $150.00

Christopher Inn
300 East Broad Street
(Auxiliary Headquarters)

Singles	$20.50 - $29.00
Doubles	$26.00 - $35.00
Twins	$30.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

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(Name of Hotel)

_____ Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 14-18, 1977 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1977.)

_____ Single Room _____ Twin Room

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Price Range _____ _____ Guaranteed _____

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Name _____

Address _____

City _____ State _____ Zip _____

PLEASE VERIFY MY RESERVATION
If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.

Rooms will be held until 6:00 P.M. unless payment is guaranteed.

COLLEAGUES IN THE NEWS . . .

IRA A. ABRAHAMSON, JR., M.D., Cincinnati, recently received the Honor Award from the American Academy of Ophthalmology. Dr. Abrahamson, Assistant Clinical Professor in the Department of Ophthalmology of the University of Cincinnati School of Medicine, is on the editorial board of both the *Pediatric Journal of Ophthalmology* and the *American Family Physician*. He has been guest speaker at numerous functions including the annual meeting of the Ohio State Society for the Prevention of Blindness at which he presented his Barraquer-Award-winning movie, "The Red Eye."

The American College of Chest Physicians recently inducted ten Ohio physicians into fellowship in the College. Fellowship, currently numbering over 10,000 physicians, denotes that a physician is a specialist in disciplines related to functions and diseases of the chest. Those inducted are **MICHAEL ALTMAN, M.D.,** Columbus; **NICHOLAS BAILAS, M.D.,** Toledo; **NORMAN H. BAKER, M.D.,** Columbus; **JAMES P. GRAHAM, M.D.,** Dayton; **JAMES A. HELMSWORTH, M.D.,** Cincinnati; **CHARLES B. PAYNE, Jr., M.D.,** Cleveland; **HOWARD J. SCHWARTZ, M.D.,** Beachwood; **C. DAVID SHOOK, M.D.,** Mansfield; **KENNETH L. WEHR, M.D.,** Hamilton; and **PAUL G. ZERBI, M.D.,** Warren.

IMMEDIATE OPENINGS
for
PHYSICIAN ADVISOR

Peer Review Systems, Inc., the Professional Standards Review Organization for Central Ohio, is currently accepting a limited number of applications from physicians who wish to be considered for selection as a part-time "Physician Advisor."

The physician shall be part of a select group and paid as a consultant at $35.00 per hour for time spent in considering and making medical determinations relative to the quality, medical necessity, and appropriateness of medical care given to Medicare and Medicaid patients. Business travel shall be reimbursed at 15c per mile. Consulting hours are flexible and may be tailored to meet the physician's schedule.

Applicants must be licensed in Ohio, and it is desirable that they be in active practice at least part-time. Experience in peer review or utilization review is desirable.

For details call Roy R. Miller, M.D., Medical Director, at 614/451-3600 at your earliest convenience.

ROBERT D. GILLETTE, M.D., Toledo, is the director of the Riverside Family Practice Center which was recently aproved by the Liaison Committee on Graduate Medical Education to offer a family practice residency. With the approval by the Committee of 16 new programs, the total number of family practice residencies in the U.S. increased to 303. Currently training more than 4,600 residents, the goal of family practice residencies is to have one-fourth of all medical school graduates entering them by 1980.

WILLIAM HERMAN, M.D., and **EARL SMITH, M.D.,** Cleveland, recently received Northern Ohio Pediatric Society (NOPS) Recognition Awards. Dr. Herman was recognized for his contribution in establishing accident prevention programs in the Cleveland area, particularly the Poison Control Center. Dr. Herman was president of NOPS in 1967-1968.

Dr. Smith was recognized for his many years of service to NOPS. Chief of Pediatrics at Mt. Sinai Hospital, Dr. Smith was one of the founders, an original officer, and second president of the Society.

RICHARD C. JUBERG, M.D., Ph.D., has joined the Wright State School of Medicine as Professor in the Department of Pediatrics. Before coming to Wright State, he was Professor of Pediatrics and Director of the Birth Defects Center at Louisiana State University School of Medicine, Shreveport. Dr. Juberg belongs to many professional organizations including the American Society of Human Genetics, American Eugenics Society, and the Society for Pediatric Research.

JAMES KILMAN, M.D., Columbus, Professor of Surgery at the Ohio State University College of Medicine, was appointed Director of the Division of Thoracic Surgery of the Department of Surgery. Dr. Kilman also became Chief of the Department of Thoracic Surgery at Children's Hospital.

JOHN C. MELNICK, M.D., Youngstown, has published his second book. Entitled *The Green Cathedral,* it is a history, geography, and nature notebook of Mill Creek Park in the Youngstown area. The text contains more than 300 photographs and illustrations, many of them taken by Dr. Melnick. His first book, *A History of Medicine in Youngstown and Mahoning Valley, Ohio,* was published in 1973.

HOWARD B. WEAVER, M.D., Canton, has been elected to the Board of Trustees of Malone College. A member of the Timken Mercy Hospital staff, Dr. Weaver is president of the Stark County Medical Society and the Canton Academy of Medicine.

If your angina patient* isn't having 3 out of 4 better days than usual... try Cardilate®

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*Please note: unstable angina patients may be refractory to all long-acting nitrates

INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED: 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

Also available: Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital* (*Warning: may be habit-forming).

1. Russek HI: AM J M Sc 239.478, 1960



"Pain days" significantly reduced with Cardilate® (erythrityl tetranitrate) in 48-patient study[1] Patients on placebo experienced same pain as usual or increased pain 2 days out of 3...compared to 1 day out of 4 while on Cardilate.

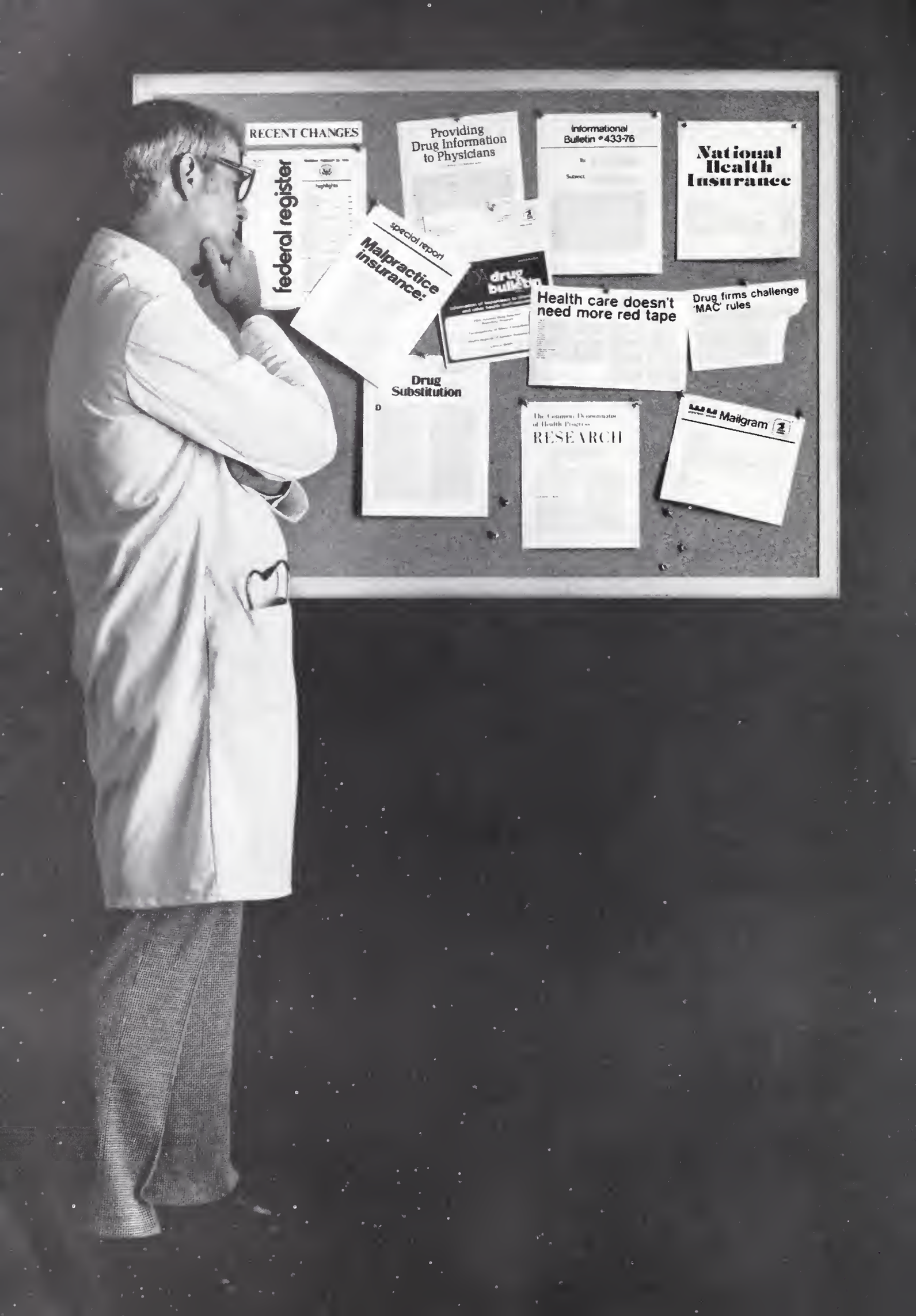
Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.

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Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

proceedings of the council

December 11-12, 1976

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 11, and Sunday, December 12, 1976, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. W. J. Lewis, C. Douglass Ford and C. Edward Pichette); Dr. John H. Ackerman, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Messrs. Joseph K. Gilmore, President, and David L. Rader, Vice President-Administration, Columbus, The Physicians Insurance Company of Ohio; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Mulgrew, Holcomb, Freeman, Ayish, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Drs. Ford and Pichette); Mr. Pohlman; Messrs. Page, Edgar, Gillen, Campbell, Clinger, Mulgrew, Holcomb, Freeman, Ayish, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson, of the OSMA Staff.

ANNOUNCEMENTS

President Bates announced the resignation of Douglas R. Houser, Assistant Director of the Department of Continuing Medical Education. Mr. Houser advised the Council he wished to return to college to complete work on his degree in accounting. The Council wished him well in his endeavor.

MINUTES

The minutes of the November 6-7, 1976 meeting and the minutes of the meeting of Council on November 22, 1976, held by conference telephone call, were **approved.**

OHIO DIRECTOR OF HEALTH

Dr. Ackerman addressed the Council on recent developments in public health. He stated that 30 percent of the eligible Ohioans had been vaccinated for A/New Jersey Influenza and that Ohio was third in the country in vaccination statistics, behind California and Pennsylvania. He added that 34 percent of the high risk population had received the bivalent vaccination (A/New Jersey and A/Victoria).

Dr. Ackerman announced the addition of a new chief of the Maternal and Child Health Department, Alice Lanier, M.D., M.P.H.

In discussion stages, according to Dr. Ackerman, is a proposal for the licensing of the owners of radiation devices covering 12,000 radiation sources within Ohio.

MEMBERSHIP

Mrs. Wisse announced that membership is running 219 ahead of 1975; the projected gain for the year is 250 members.

FISCAL MATTERS

The minutes of the December 10 meeting of the Committee on Auditing and Appropriations were presented by Dr. Rinderknecht. The minutes were approved as was the 1977 budget. (See *The Journal,* Vol. 73, No. 1, Jan. 1977.)

AMERICAN MEDICAL ASSOCIATION

Mr. Campbell reported on the actions of the AMA House of Delegates' Clinical Session held December 4-8, 1976, in Philadelphia. The Council discussed AMA proposals for direct billing of physicians by the AMA. It was decided to continue the discussion at the January meeting of the Council.

It was announced that Ohio will lose an AMA Delegate in 1977, and the problem of developing a method of reducing the delegation complement was referred to an Ad Hoc Committee under the chairmanship of Dr. Dorner. Other members of the committee are Drs. Diller, Pfahl, and Rinderknecht.

CONTINUING MEDICAL EDUCATION

Mrs. Dodson reported on the plans for the 1977 Annual Meeting. The future structure of the Annual Meeting was officially docketed for discussion at the unstructured meeting of the Council, to be held March 11-13, 1977.

The Council discussed the program involving the "Role of the Professions in Society," voted to participate as an association, and designated Donald J. Vincent, M.D., to represent the Association in the organization. Mrs. Dodson received the staff assignment with regard to relations with this organization.

MEDICAL ADVANCES INSTITUTE

The Council visited the Battelle Columbus Laboratories to review a demonstration of the MAI Hospital Peer Review System, computer version, batch mode, which was conducted by the Battelle staff. Vergil N. Slee, M.D., President of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, was present and participated in the conference.

Subsequently, the Council, after extensive discussion, adopted the following statement with regard to Medical Advances Institute:

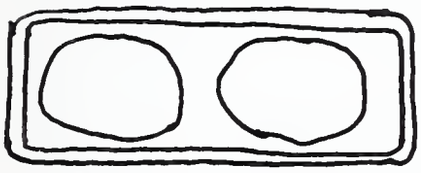
1. The Council reaffirms its support of the MAI Hospital Peer Review System as developed under direction of the House of Delegates.

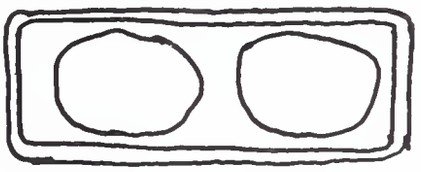
2. The Council supports the medical staffs of hospitals who wish to utilize the MAI Hospital Peer Review System and encourages recognition of it by Ohio Professional Standards Review Organizations, Blue Cross, Private Insurance, Medicaid, Medicare, and others as an appropriate quality assurance system.

(continued on page 108)

Leasing your new car can make good business sense.

Right now, many business and professional people are considering buying a new car. But before you put down a penny of down payment, consider leasing instead. There are several sound financial reasons that favor leasing—possible tax advantages or the cash flow aspects, for example. Your accountant or tax advisor can evaluate how leasing can affect your individual financial picture. We can offer you two choices: purchase financing or, in cooperation with a group of area auto dealers, lease financing. It will only take a few moments of your time to determine whether leasing a car would be good business for you. If it is, we can help you apply to lease from a participating dealer, almost any make, model and color new car you'd like, with any optional equipment you'd like.





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(continued from page 106)

3. The Council authorizes education and information assistance by *The OSMA Journal,* through meetings and other means to inform the membership about the status and availability of the MAI Hospital Peer Review System.

4. The Council supports the MAI Officers and Board in their negotiations with the Commission on Professional and Hospital Activities on the marketing of the computerized versions.

A proposal from MAI, dated December 3, 1976, asking the OSMA to become a part of the Ohio Health Data Corporation was presented to the Council and was referred to an ad hoc subcommittee (Dr. Hartle, chairman, and Dr. Lewis) for study and report. Mr. Gillen was designated to provide staff assistance.

OHIO MEDICAL INDEMNITY, INC.

Dr. Lieber and Mr. Gillen reported on the OMI Board of Directors meeting of November 17, 1976.

PICO

It was the decision of the Council to borrow $1,500,000 in order to purchase 1500 shares of Class A common stock in the Physicians Insurance Company of Ohio (PICO), in order to permit the terms of the escrow agreement to be fulfilled and for PICO to receive its license from The Department of Insurance.

This was done to permit PICO to serve OSMA members by the beginning of the new year 1977.

The loan is to be paid by the sale of the 1500 shares to physicians as they qualify themselves to purchase insurance over the next 30 to 60 days.

Appropriate resolutions were passed authorizing the bank loan.

By official action, the Council voted to designate Dr. Wells or Dr. Thomas or Dr. Gaughan to vote the Ohio State Medical Association's Class B stock at the first shareholders' meeting of The Physicians Insurance Company of Ohio.

An up-to-date progress report on the operation of PICO was presented by Mr. Gilmore. Mr. Gilmore presented a tentative budget for 1977 representing an expense ratio of 3.85 percent and announced that a budget compliance report would be published monthly for the Board of Directors. He stated that two subsidiaries wholly owned by The Physicians Insurance Company of Ohio, a premium finance company and an agency, are being organized.

The Council, as sole incorporator of PICO, **approved** the organization of the two wholly owned subsidiaries.

Dr. Thomas, chairman of the PICO Underwriting Committee, reported on two meetings of that committee. Subsequently, the Council adopted the following resolution: "Resolved, that the Ohio State Medical Association acting as an agent, at the request of The Physicians Insurance Company of Ohio, provides support service through the Council, so that PICO underwriting structure may be divided into Councilor District lines with each councilor organizing his district with appropriate representatives from each county medical society being available to transmit peer review information for underwriting purposes."

COMMITTEE REPORTS

Committee on Membership and Planning

The minutes of the November 13-14, 1976 meeting of the Committee on Membership and Planning were presented by Mr. Gillen. The Council **approved** the committee's recommendation of a conference on "cost effectiveness," such conference to be of 20 to 25 leaders representing industry, labor, agriculture, insurance, the media, government, etc.

The Council voted to explore with the AMA the possibility of utilizing the Ohio data in this year's AMA membership opinion survey.

Also **approved** was the committee's recommendation that an ad hoc subcommittee (Oscar Clarke, chairman, Dwight L. Becker and S. Baird Pfahl) be assigned the task of developing projection of future trends in Ohio medicine and recommending contingency plans.

The Council voted to invite the members of the Committee on Membership and Planning to attend the unstructured meeting of the Council, March 11-13.

The minutes, as a whole, were **approved.**

Committee on Mental Health

The minutes of the November 14, 1976 meeting of the Committee on Mental Health were presented by Mr. Clinger. The Council **approved** the committee's recommendation for a project to gather information throughout the state on the experience of psychiatrists, hospitals, and probate courts with regard to the provisions of H.B. 244, passed by the Ohio Legislature in 1976, and to cooperate in a coalition with other interested agencies to study the Act and consider necessary amendments.

Ad Hoc Committee on Quality Health Care

The minutes of the meeting of the Ad Hoc Committee on Quality Health Care, of November 24, 1976, were presented by Mr. Clinger. The minutes were accepted for information.

Commission on Medical Education

The minutes of the December 1, 1976 meeting of the Commission on Medical Education were presented by Mrs. Dodson. In approving the minutes, the Council **approved** the suggestion that when applying for accreditation, institutions should notify the county medical society to ask for their endorsement.

Four guidelines were adopted at the suggestion of the commission with regard to accreditation procedures, as follows:

A. Specific guidelines be established for the members of the site survey team which would include a check-off list of items for the team to review at time of survey.

B. That various members of the Committee on Education be responsible for reviewing completed applications and

survey reports following the survey. Their recommendations should be considered before Commission approval.

C. First-time applicants for accreditation should be given two-year accreditation only. An exception might be an institution which has had an established, documented program for several years.

D. An Ad Hoc Committee be established to develop guidelines for the Commission to use in the resurveying of institutions, hospitals, and organizations for accreditation.

Task Force on Professional Liability

The minutes of the meeting of the Task Force on Professional Liability held December 1, 1976 were presented by Mr. Campbell. Mr. Campbell discussed two of the Task Force projects: the Franklin County court docket survey and the survey on public attitudes toward health care and medical malpractice, both conducted by Management Horizons, Inc. The study on public attitudes was referred to the Committee on Public Relations for further study and implementation.

A suggested counterclaim research project procedure was reviewed by the Council and was approved for implementation.

Ad Hoc Committee to Study Second Opinion Consultation

A report on the December 10, 1976 meeting of the Ad Hoc Committee to Study Second Opinion Consultation was presented by Dr. Hogg, the chairman. Subsequently, the Council voted to instruct the committee to develop policies and guidelines for surgical "second opinions."

COUNCILOR REPORTS

The Councilors reported on activities in their respective districts.

FEDERAL LEGISLATION

Mr. Edgar presented a written report on federal legislation.

STATE LEGISLATION

Mr. Mulgrew and Mr. Ayish reported on possible and probable legislative proposals which will be before the Ohio General Assembly session beginning in January 1977. These include the following: medical malpractice, definition of death, optometric law changes, ancillary/paramedical groups licensing bills, patient's Bill of Rights, laboratory registration, "Living Will," hospital licensure, revision of the mentally ill commitment procedures, redrafting of the Medical Student Loan Commission funding, revision of HMO laws, revision of Nursing Home Licensing Bill, generic drug substitution legislation, revision of the new pap test requirement, patients' records and privacy bills, fluoride restrictions, lay members on all

(continued on page 110)

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Medical Director

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(continued from page 109)

licensing boards, abolition of the Medical Licensing Board, regulations on delivery of emergency health care, restructuring of the Welfare Department to create a Medical Services Bureau, revision of the new Workmen's Compensation Bill, and revision of the new Medicaid Bill.

CONSTITUTION AND BYLAWS

Amendments to the Lake County Medical Society Constitution and Bylaws were approved by the Council.

The Council also approved the reissuance of the Charter of the Butler County Medical Society.

LEGAL COUNSEL REPORT

Mr. Pohlman reported on lower-court decisions in Cleveland and Columbus affecting certain provisions of H.B. 682, the Omnibus Medical Malpractice Act. The Council voted unanimously that the Ohio State Medical Association act in the role of *amicus curiae* to undertake to uphold the contested provisions of the Act.

FIELD SERVICE REPORT

The field service report was presented in writing by Mr. Holcomb.

OHIO STATE MEDICAL JOURNAL

A report with regard to the *Ohio State Medical Journal* was presented by Mrs. Jacobson.

PUBLIC RELATIONS

Ms. Doll reported that a meeting of the Committee on Public Relations would be held early in January.

JUA STATISTICS

JUA statistics were presented in writing by Mr. Campbell.

SINGLE SHOT VOTING

Dr. Dorner reported for the Ad Hoc Committee on Single Shot Ballots. The Council voted to submit, from the Council, a resolution for the House of Delegates proposing an amendment to the Bylaws to define valid ballots in elections.

TRAVEL PROGRAM

The following 1977 travel program with INTRAV was approved:

Trans-Panama Air/Sea Cruise—February 4
Alps-Riviera Adventure—June 4
Classical European Adventure—August 28
Orient Adventure—November 8

In addition, an experimental program with International Travel Associates, Inc., was approved for September 28, involving Rome and London. This program would permit air-fare-only passengers on a limited basis.

COMMENDATIONS

The Council noted the forthcoming retirement of Mrs. Gladys Davidson, Executive Secretary of the Lorain County Medical Society; and Mrs. Kay Ticknor, Executive Secretary of the Trumbull County Medical Society. The Council voted to commend them on their long service to medicine, thank them for their many courtesies to the Ohio State Medical Association, and wish them well.

ADJOURNMENT

There being no further business, the meeting was adjourned. The next meeting of the Council is scheduled for January 29-30, 1977.

ATTEST: Hart F. Page
Executive Director



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Telephone: 614/228-6971

Classified Ads

Rates: $2.00 per line. Display classified: $4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

SEEK EMERGENCY ROOM POSITION: Full-time. 38 years old. Reply Box 783, c/o Ohio State Medical Journal.

FAMILY PRACTITIONERS, OB-GYN, AND GENERAL INTERNISTS: Health Central, a new, prepaid, group practice, seeks progressive physicians eager to assist with the development of an innovative health care delivery system. Must be committed to preventive care and physician group practice. Should have a strong interest in working closely with other health care professionals and consumers. Salary range $35,000-$45,000, with excellent fringe benefits. University town with medical schools. Located in state capital; community of 250,000 served by four hospitals. Contact Robert Chesky, M.D., Medical Director, Health Central, 3401 East Saginaw, Suite 109, Lansing, MI 48912.
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BOARD-CERTIFIED PHYSICIAN'S ASSISTANT seeking a private or group practice in Ohio. Eighteen months primary care experience. Contact Charles Webster, 2422 McMillan Ct., Rock Island, Illinois 61201, phone 309/794-0030 before 5 PM.

(**Editor's Note:** *The Journal* presents the above classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.)

NEEDED, PHYSICIANS in all specialties throughout Ohio to evaluate patients applying for disability under the Social Security Disability Programs. If you are interested, please contact John E. Hastings, M.D., Chief Medical Consultant or Mr. James Wallace, Deputy Administrator for Social Security. Phone 800/282-9330, ext. 7457 or 6393.

THREE BOARD-CERTIFIED FAMILY PHYSICIANS looking to recruit family physician graduate or board-qualified or certified family physician as an associate in a semi-rural small town, group practice. Progressive community; local liberal arts college; excellent local community hospital; and 35 miles from Columbus, Ohio. A very good setting in which to practice, live, and raise a family. Contact Granville Medical Center, Inc., Granville, Ohio 43023, phone 614/587-0115.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third partner to practice. New facility. Excellent hospital within walking distance. (See **FAMILY PRACTICE POSITION AVAILABLE** ad this issue for more detailed information.) Contact Robert Flint (614/382-8211), Marion General Hospital, Marion, Ohio 43302.



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FOR SALE: New two-story, brick, medical bldg. in Cleveland suburb, Euclid. Three doctors' offices first floor, two suites or apartment second floor. Parking for 20 cars front and rear. On bus stop. Two blocks from shopping area. Price $90,000. Physician can take over established general practice office. Gross income from rent $10,000 per year. See by appointment 4 to 7 PM except Thursdays. Phone 216/481-3058 or 216/383-8225, Euclid, Ohio.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FAMILY PRACTITIONER OR GENERAL PRACTITIONER urgently needed to take over practice in city of 13,000 thirty minutes from Cleveland. Reply Box 784 c/o Ohio State Medical Journal.

EMERGENCY DEPARTMENT DIRECTOR: 20% administrative, 80% clinical, with national emergency room group in Ohio. Annual minimum guarantee $55,000-$65,000. Contact Drs. Cooper or Spurgeon 1-800-325-3982; Box 11241, St. Louis, Missouri 63105.

OHIO — EMERGENCY ROOM PHYSICIAN: Full time, 4 or 5 days per week. Near Cleveland, Akron, and Youngstown. Hourly rate. Contact S. Sami Solu, M.D., Chief, Robinson Memorial Hospital, Ravenna, Ohio 44266. Phone: 216/297-0811.

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GENERAL SURGERY RESIDENCY PROGRAM: New, five-year program reactivated at Lutheran Medical Center, Cleveland, Ohio. Positions are available at PGY2 and PGY3, beginning July 1977. Candidates must be graduates of American or Canadian Schools of Medicine. Contact Joseph C. Avellone, M.D., Director of Surgery, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland, Ohio 44113.

PSYCHIATRISTS: City/County of 66,000 has critical need of a psychiatrist. Will affiliate with MH Area Counseling Center. Excellent salary, benefits and physical facilities. (See FAMILY PRACTICE MEDICAL POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint (614/382-8211), MARION GENERAL HOSPITAL, Marion, Ohio 43302.

PRACTITIONERS: TIRED OF LONG HOURS? Have you considered an exciting, hospital-based specialty? We have one, and an excellent training program in Rehabilitation Medicine. Two vacancies for July 1977. Write Dr. C. Long, CWRU-affiliated Program, Highland View Hospital, 3901 Ireland Dr., Cleveland, Ohio 44122.

PHYSICIAN WANTED: General surgeon— Thoracic, experience preferred. To replace retiring surgeon in association with board certified surgeon, northeast Ohio. Small university town. Modern hospital with residency training and medical school affiliation. Reply Box 786 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone 216/946-4546.

RADIOLOGIST needed by 40-physician, multispecialty, group practice in southeastern Ohio. Paid liability insurance, excellent benefits, salary negotiable. Contact: Robert E. Daniel, Administrator, 614/446-5187, or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

OFFICE FOR RENT: COLUMBUS. New office building: 5 min. from Mercy Hospital, 10 min. from Mt. Carmel Hospital, and 10 min. from Grant Hospital. Will tailor office to requirements. Ample off-street parking; bus stop on corner. Air conditioned. Phone days: Robert E. Horowitz, 614/444-1151.

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ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

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NEUROLOGIST needed by 40-physician, multispecialty, group practice. Modern, excellently equipped building adjacent to 265-bed, acute-care hospital in southeastern Ohio. Excellent benefits, paid liability insurance, salary negotiable. Contact: Robert E. Daniel, Administrator, 614/446-5187 collect, or write Holzer Medical Center Clinic, P.O. Box 344, Gallipolis, Ohio 45631.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and 250-bed general hospital with privileges available. (See FAMILY PRACTICE POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint (614/382-8211), MARION GENERAL HOSPITAL, Marion, Ohio 43302.

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EMERGENCY PHYSICIANS needed in Northeast Ohio to work in busy emergency department of a 500-bed community hospital. Initial salary, $45,000-$50,000. Reply Box 728, c/o Ohio State Medical Journal.

PSYCHIATRISTS: Immediate opportunity to develop a new mental health counciling center for a city/county population of 30,000 and to practice privately. Starting salary $50,000. An excellent opportunity for a young man who wants to put some of his ideas in community psychiatry into practice. Contact A. C. Diller, M.D., President, (419/749-2114), Van Wert County Mental Health Board, Medical Arts Building, Van Wert, Ohio 45891.

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THE OHIO STATE Medical Journal

MARCH 1977
Volume 73, Number 3

Measles

A Disease That Shouldn't Happen

MEASLES IN OHIO – UPDATE, PAGE 147

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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OSMA-Member Insurance
QUESTIONNAIRE

Dear Doctor:

The OSMA has been much involved over the past few months in establishing the Physicians Insurance Company of Ohio (PICO). We are confident that the formation of PICO will be a major factor in solving the malpractice insurance crisis for our members in Ohio.

We are now being asked by many of our members when PICO will be able to resolve other insurance problems such as homeowners, automobile, commercial fire, and the like. Obviously, the Board of Directors and shareholders will control the actions of PICO. If, however, the demand by shareholders is sufficient, we at the OSMA will exert whatever influence we have so that PICO will continue to be responsive to members' needs.

In an effort to determine wishes and needs of you, the membership, we are asking that you take a few minutes to complete the following questionnaire to indicate to the OSMA your insurance needs. Please read it carefully and return it to the OSMA by April 15, 1977.

Thank you for your cooperation in allowing us to continue to provide members with new and innovative membership services.

Very Truly Yours,

Hart F. Page

Hart F. Page, CAE
OSMA Executive Director

This questionnaire appears in the March issues of both The Journal and the OSMAgram. Please fill out one.

---

1. Are you satisfied with the performance and rates of your present automobile insurance company?

☐ Yes ☐ No ☐ No Opinion

2. Are you satisfied with the performance and rates of your present homeowners insurance company?

☐ Yes ☐ No ☐ No Opinion

3. Some insurance companies use agents, and others deal directly with their policyholders. Given the choice, would you prefer to deal through an agent or directly with your insurance company?

☐ Agent ☐ No Agent ☐ No Opinion

4. Would a savings of 15% be sufficient to make you change insurance companies even if you are satisfied with your present insurance company?

☐ Yes ☐ No ☐ No Opinion

5. If Physicians Insurance Company of Ohio offered automobile and homeowners coverage, would you be interested in a premium quotation?

☐ Yes ☐ No ☐ No Opinion

6. If PICO were to offer additional lines of insurance, would you prefer using agents or dealing directly with PICO?

☐ Agents ☐ Direct with PICO ☐ No Opinion

7. Are you satisfied that your present agent performs in a manner commensurate with his remuneration?

☐ Yes ☐ No ☐ No Opinion

8. Did your previous or does your present malpractice insurance company require that you place all of your other insurance business with the company?

☐ Yes ☐ No

9. Would you be interested in a policy that would cover all of your professional exposures except malpractice?

☐ Yes ☐ No ☐ No Opinion

10. Do you feel PICO should investigate the feasibility of offering additional lines of insurance?

☐ Yes ☐ No ☐ No Opinion

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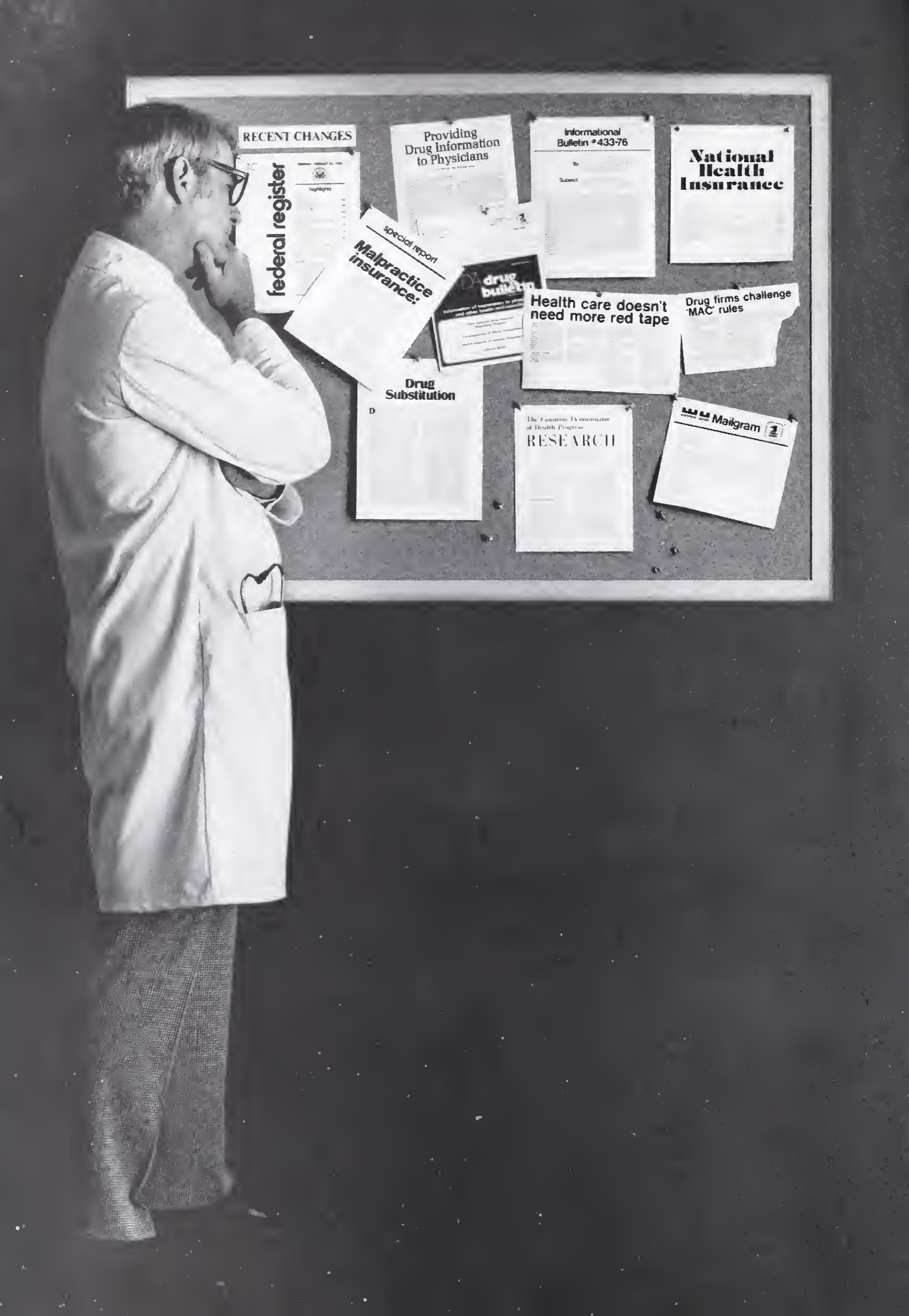
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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ohio medical school highlights

The Concept of Medical Education at the Medical College of Ohio

John P. Kemph, M.D., Dean

All of the health education programs at the Medical College of Ohio (MCO) have been initiated by its four schools: medicine, graduate studies, nursing, and allied health. The first of these programs to be developed was the medical school. The Charter Class of 32 medical students entered the Medical College of Ohio in 1969. Since that time, the entering classes have gradually increased in size to 115 students in the current first-year class admitted in July 1976. The goal for class size is 150 students by 1980, with no further increases anticipated.

Initially, the MCO facilities were set up in the Maumee Valley Hospital, Lucas County Home, and Roche Memorial Hospital, formerly operated by Lucas County. This complex has come to be known as the Medical College of Ohio East Campus. A new campus is under construction nearby on a 327 acre tract known as the West Campus.

The first completed West Campus building, the Health Sciences Building, was opened in September 1973. The Library-Administration Building, named the Raymon H. Mulford Library, was ready for occupancy in March 1975. The Health Education Building opened in late 1975. Construction of a 258-bed teaching hospital is now underway, with completion scheduled for 1979. Ground breaking for a fifth building with office and support facilities has just begun.

The Medical College of Ohio is the 100th medical school in the country, the 4th in the State of Ohio, and the 2nd state assisted. Its proximity to the University of Toledo and Bowling Green State University has occasioned cooperative academic programs. In 1970, the Medical College took the leadership in the planning, implementing, and regionalizing of community college nursing and allied programs. Continued inter-university cooperation has resulted in the formation of the Corsortium of Health Education in Northwest Ohio. Since 1971, nursing education, leading to both associate and baccalaureate degrees, and various allied health programs have increased enrollment in cooperation with both universities.

Graduate medical education is furnished in cooperation with five Toledo hospitals. The residency programs are under the direction of the Medical College of Ohio clinical departmental chairmen of medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. Programs in continuing medical education are also offered under the direction of the associate dean for continuing education.

A doctoral program has received approval by the Ohio Board of Regents. The program, offering a doctor of philosophy in medical sciences degree, began in September 1975.

Objectives of the Medical College

The objectives of the Medical College of Ohio will be described in the areas of education, research, and service. In general, the educational objective is to provide excellent academic programs for students in a variety of disciplines in health education. Undergraduate, medical education objectives are viewed in the context of a continuum of education from medical school to life-long continuing education. It is becoming increasingly difficult to teach all that is known about medical sciences because of the burgeoning medical technology and the tendency to shorten time spent in medical school. Thus, it is assumed that the three years of medical school at MCO will merely prepare the student as well as possible for the next phase of this life-long educational process, in view of the limited time allotted.

Education

In several faculty-student retreats, where our curriculum has been evaluated and reevaluated, the term "undifferentiated physician" has been proposed as the most appropriate of several terms to describe our student when he graduates from MCO. The intent is to provide the student with adequate basic and clinical skills and knowledge, but even further, to provide an integrating capacity to make sound clinical judgments. It is hoped by the faculty who planned the MCO educational program that an integrated, three-year curriculum would foster the development of an integrating capacity and, at the same time, partially meet governmental and societal demands to decrease the total time required to obtain the degree of Doctor of Medicine. This type of curriculum is more demanding on the students and faculty than a traditional, departmentally oriented curriculum. Mature students perform better than younger, less-stable students in this curriculum; and, therefore, it will be difficult to adapt to shorter periods of time by taking candidates after three years of premedical training. In fact, we appear to be accepting more mature students without any organized design or plan to do this. It is unlikely

(continued on page 122)

that the time in premedical or medical school can be reduced any further except in the case of the outstanding student; instead, we are adding two months to the curriculum for the class which entered in 1976 in response to recommendations of faculty and students to provide needed additions to the curriculum without changing its basic philosophy or structure.

One of the major aims of this educational program is sufficient exposure to basic and clinical science so that the student will be able to decide the direction he should take in the next stage of his education. Although most of our graduates are taking the primary care specialties of internal medicine, pediatrics, and family medicine, many are taking other specialties, and a few have indicated an interest in academic medicine. We expect a significant number to elect a flexible internship because they may not have sufficient time to decide on a more definitive program. Therefore, we provide a sufficient quantity of these internships and allow flexibility in the time of entry and encourage more time in medical school if needed. After residency, continuing education programs are provided by MCO primarily for the physicians who practice in the 20 counties of northwest Ohio. Although both the States of Ohio and Michigan have passed laws requiring physicians to take at least 50 hours of continuing education each year, MCO departments provide programs to allow most physicians much more than that required. The educational process in medical school should set the stage for a lifelong love of learning, not just the acquisition of new information but, rather, receptiveness to new attitudes and readiness for change.

In 1969, when the Medical College began development of graduate medical education, there were 60 first-year graduate medical education positions offered in Toledo hospitals. Not a single position was filled by an American medical graduate through the National Internship Matching Plan that year. Most of the existing residency positions were absorbed into the MCO and associated hospitals' graduate education programs in 1969. The first year there was a total of 64 residents, one of whom was an American medical graduate. On July 1, 1976, there were 218 interns and residents enrolled in the MCO graduate program. Of these physicians-in-training, 100 (46 percent) are American medical graduates; and 41 are former MCO students. Of 77 first-year positions, 42 (55 percent) are American medical graduates.

Research

There also is a goal in research. Both the performance and teaching of research are increasingly in the foreground of MCO objectives. About two years ago, the Ohio Legislature indicated a strong preference to support teaching programs rather than research. The MCO research support from outside resources was minimal. At that time, a major objective became the acquisition of research grants to support our budding research efforts. The faculty responded with surprising capacity for writing successful proposals for research grants. Currently, most faculty members in some departments have research grants. MCO aims to become a major basic and clinical research center.

Beginning in the first year of the medical curriculum, all students were required to participate in independent research studies. This program was not popular with the students; and the requirement was removed after all members of the first class completed research projects. A small number of students in subsequent classes continue to engage in research activities. The MCO goal of developing researchers will soon be realized as our doctoral program in medical sciences (now in its second year) matures.

Service

MCO has been designated by the Ohio Board of Regents as the center for health education in northwest Ohio. To utilize several faculties and avoid duplication of health education programs, Bowling Green State University, the University of Toledo, and MCO have formed the Consortium of Health Education of Northwest Ohio (CHENO). CHENO is committed to the development of quality, post-secondary, health education programs and to the provision of leadership in responding to health manpower needs of the region. Its essential purposes are to:

A. Evolve a planning mechanism to coordinate health education program planning in relation to the needs of the health care system in northwest Ohio.
B. Expand efforts to regionalize continuing education for all levels of health personnel in northwest Ohio.
C. Evolve planning for preventive health education and practice in northwest Ohio.
D. Solicit public and private support for health education programs in northwest Ohio.

Five areas have been designated for initial exploration: (1) physical rehabilitation services, (2) health services and computer technology, (3) gifted and talented student career opportunities, (4) a continuing education system for health care personnel, and (5) preventive health education. A task force of three persons from each institution will be established to study each area.

MCO's goal in patient service and patient-service-related research is to provide tertiary care centers at MCO Hospital and its associated hospitals so as to develop a faculty of specialists and reinforce the existing primary and secondary care centers in the 20 counties of northwest Ohio. The first accomplishment toward this goal was establishing total renal care at MCO Hospital. This care includes dialysis, kidney transplants, tissue typing, home dialysis training, and organ procurement. Since its first transplant in early 1972, total renal care has expanded to a point where today more than 25 transplants are performed each year, meeting the requirements for unconditional federal approval. Only the

Cleveland Clinic and The Ohio State University exceed this number of transplants within Network 22, a federal area which includes most of Ohio and part of Pennsylvania, encompassing Pittsburgh and its surrounding communities.

Research and clinical cardiovascular programs including open heart surgery and comprehensive diagnostic facilities have been developed over the last several years at MCO through the investment of $1.5 million in institutional resources. Within the same time period, MCO initiated an 11-county, emergency-medical-service program which has attracted more than $2 million in federal support. A trauma-intensive-care unit at MCO Hospital for training, research, and service reinforces this effort.

Funds exceeding $1.5 million have been set aside for a program in oncology which will be centered around the radiation therapy center in the new MCO Hospital. At the request of the local health care community and with the approval of the local health planning agency, MCO has developed plans for a center in rehabilitation medicine which is expected to cost $3 million. Other strong programs at MCO Hospital include pediatric surgery, the physiology of reproduction, and the metabolic and nutritional problems associated with trauma and multidisciplinary-epilepsy-team treatment including stereotactic neurosurgery.

Tertiary care centers at the associated hospitals closely associated with MCO include the Burn Unit and Retina Clinic at St. Vincent Hospital and Medical Center, the Perinatal Care Unit at Toledo Hospital, and a Neurosciences Service at Mercy Hospital, which includes neurosurgery and neurology and is expected to include a regional, spinal-cord-injury center.

Faculty Recruitment Continues

Although the initial phase of the development of the faculty of the educational programs has been achieved, recruitment of high-caliber, scholarly faculty continues to be the most crucial facet of our development. Currently, our faculty consists of 215 full-time, 29 part-time, and 439 volunteer members. Each of our basic and clinical science departments has reached a point of productivity of which we can be proud. However, in our second phase of growth, it will become necessary to recruit an additional 50 full-time faculty and more part-time and volunteer faculty in order to achieve our educational goals. In our second phase of development, much more of our undergraduate and graduate medical education must eventually be performed in our associated and affiliated hospitals with the assistance and full cooperation of community physicians. Our associated hospitals, which include Mercy Hospital, Toledo Hospital, St. Vincent's Hospital and Medical Center, and the Toledo Mental Health Center, provide an opportunity for graduate and undergraduate clinical teaching in several clinical disciplines. Although only one hospital, Riverside Hospital, currently is affiliated with one department of the medical school,

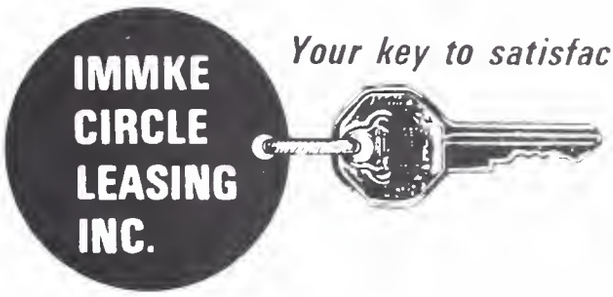
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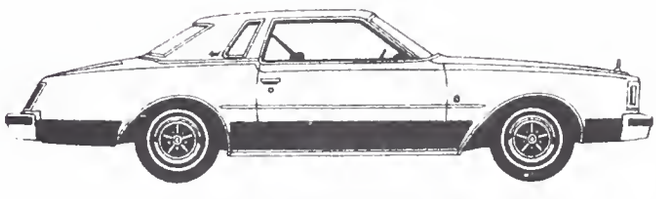
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The workshops will be held in four Ohio cities: Columbus, March 22 (OSMA Headquarters); Dayton, March 23 (Imperial House North); Bowling Green, March 24 (Holiday Inn); and Cleveland, March 25 (Marriott Inn). The cost of the workshop is $62.50. Contact: Department of Continuing Medical Education, OSMA Headquarters, 600 S. High St., Columbus, telephone: 614/228-6971.

The OSMA is cosponsoring a "Critical Care Symposium" with Grant Hospital, Columbus, to be held April 27. Covering acute dialysis, general (adult) trauma, monitoring the multi-injured patient, pediatric trauma, and shock lung, the symposium offers seven Category I credit hours.

Arnold Sladen, M.D., Director, Surgical Intensive Care Unit, Montefiore Hospital, Pittsburgh, is a member of the guest faculty. Other faculty include: Larry C. Carey, M.D., Professor and Chairman, Department of Surgery, Ohio State University College of Medicine; Bruce G. MacMillan, M.D., Chief of Staff, Shriners Burns Institute, Cincinnati Unit; and Thomas S. Morse, M.D., President, American Trauma Society and Director of Outpatient Surgical Service, Children's Hospital, Columbus.

The course will be held in Baldwin Hall of Grant Hospital School of Nursing from 8 AM to 4 PM. Registration by April 18 is necessary. Fee for the course (which includes lunch) is physicians: $25, residents: $10, paramedical personnel: $10, medical students: None (may purchase lunch tickets). Contact: Jerry T. Guy, M.D., Program Chairman, 327 E. State St., Suite 104, Columbus 43215, telephone: 614/461-3588 or 461-3290.

Periodic Programs

PEDIATRIC GRAND ROUNDS: Friday, each week, except holiday weeks; Mt. Sinai Hospital Auditorium, Cleveland; sponsor: Mt. Sinai Hospital; 1 credit hour; contact: Dr. Arnold B. Friedman, Mt. Sinai Hospital, Cleveland 44106, phone: 216/795-6000, ext. 236.

GRAND ROUNDS AND EDUCATIONAL CONFERENCES: Every Friday, 12 noon; Licking Memorial Hospital, Newark; sponsor: Licking Memorial Hospital; 1 credit hour; contact: Ralph E. Pickett, M.D., Vice President, Medical Affairs, Licking Memorial Hospital, 1320 West Main Street, Newark 43055, phone: 614/344-0331, ext. 397.

Single Course Offerings

March 1977

CONTINUING MEDICAL EDUCATION CONFERENCE: March 19; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour per conference; contact: Ernest Henson, M.D., 1343 N. Fountain Blvd., Springfield 45501, phone: 513/399-7121, ext. 341.

SYMPOSIUM ON APPROACHES TO PAIN: March 19-20; Stouffer's Dayton Plaza Hotel, Dayton; sponsor: Wright State University School of Medicine; cosponsor: Dept. of Postgraduate Medicine and Mercy Medical Center, Springfield; 11 credit hours; fee: $75; contact: Arlene Polster, Program Coordinator, Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/429-3200, ext. 376.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: March 22, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

PROBLEMS IN THE MANAGEMENT OF CARDIAC PACING: March 22, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

12TH ANNUAL CANCER SYMPOSIUM: March 23-24; Akron City Hospital, Akron; sponsor: Akron City Hospital; 10½ credit hours; fee: $50 ($10 students); contact: Debbie Harwell, Akron City Hospital, 525 E. Market St., Akron 44309, phone: 216/375-3202.

THE 1977 SEMINAR ON BREAST DISEASES: March 26; Cleveland Museum of Natural History, Wade Oval, University Circle; sponsor: Huron Road Hospital; 6 credit hours; fee: $50 ($25 residents); contact: Department of Medical Education, Huron Road Hospital, 13951 Terrace Road, Cleveland 44112, phone: 216/851-7000, ext. 368.

TEACHING AND YOUR PRACTICE: March 26-27; Marriott Inn, Columbus; sponsor: Ohio Academy of Family Physicians; 8¾ credit hours; fee: $50 ($25 AAFP residents); contact: Ohio Academy of Family Physicians, 4075 North High St., Columbus 43214, phone: 614/267-7867.

ACUPUNCTURE AND TRANSCUTANEOUS STIMULATION—HERE TO STAY?: March 29, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: March 29, 7:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

(continued on page 126)

SECOND JAMES F. BEATTIE MEMORIAL SYMPOSIUM: March 30, 9 AM-4 PM; Hospital Auditorium, Mount Carmel Medical Center, Columbus; sponsor: Mount Carmel Medical Center; 6 credit hours; fee: $3; contact: William R. Hughes, Ph.D., Director of Education, Mount Carmel Medical Center, 793 West State Street, Columbus 43222, phone: 614/225-5000.

April 1977

INFECTIOUS DISEASE CONFERENCE: April 5, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CANCER OF THE GALLBLADDER AND BILIARY TRACT: April 12, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: April 12, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

RENAL FUNCTION IN SEVERE LIVER DISEASE: April 12, 8:15 PM; Steubenville Country Club; sponsor: Fort Steuben Academy of Medicine; 1 credit hour; contact: B. B. Greenhouse, M.D., Steubenville, Program Chairman.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: April 19, 7:30 AM: Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DERMATOLOGY CONFERENCE: April 19, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

SPORTS MEDICINE SYMPOSIUM: April 24, 1-6 PM; Steubenville Country Club, Steubenville; sponsor: Ohio Valley Chapter — Ohio Academy of Family Physicians; cosponsors: Ohio High School Athletic Association, Fort Steuben Academy Foundation; 6 credit hours; fee: $10 (physicians) no fee (coaches, trainers, nurses, interns); contact: Sanford Press, M.D., 525 N. Fourth Street, Steubenville 43952, phone: 614/282-4893.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: April 26, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

MORBID OBESITY WITH INTESTINAL BYPASS: April 26, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CARE OF MENTALLY RETARDED IN MARION COUNTY: (Jerry Manuel, Superintendent, Marca Schools, speaker); April 28; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

THE DISABLED PHYSICIAN AND HIS FAMILY: April 29-May 1; Kings Island Inn, Mason; sponsor: Ohio Academy of Family Physicians; 8 credit hours; fee $40 (AAFP member); $65 (non-member); $30 (FP resident); contact: Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

May 1977

CONTINUING EDUCATION PROGRAM IN NUCLEAR MEDICINE FOR PHYSICIANS: May 9-13; July 11-15; November 14-18; Hillcrest Hospital/Nuclear Medicine Institute, Cleveland; sponsor: Nuclear Medicine Institute; cosponsor: Hillcrest Hospital; 40 credit hours; fee: $100; total tuition including registration fee: $500 ($200 residents); contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

SELECTION OF MEDICAL STUDENTS AND CURRENT ASSESSMENT OF THEIR PROFICIENCY: (J. Hutchison Williams, M.D., speaker); May 12; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

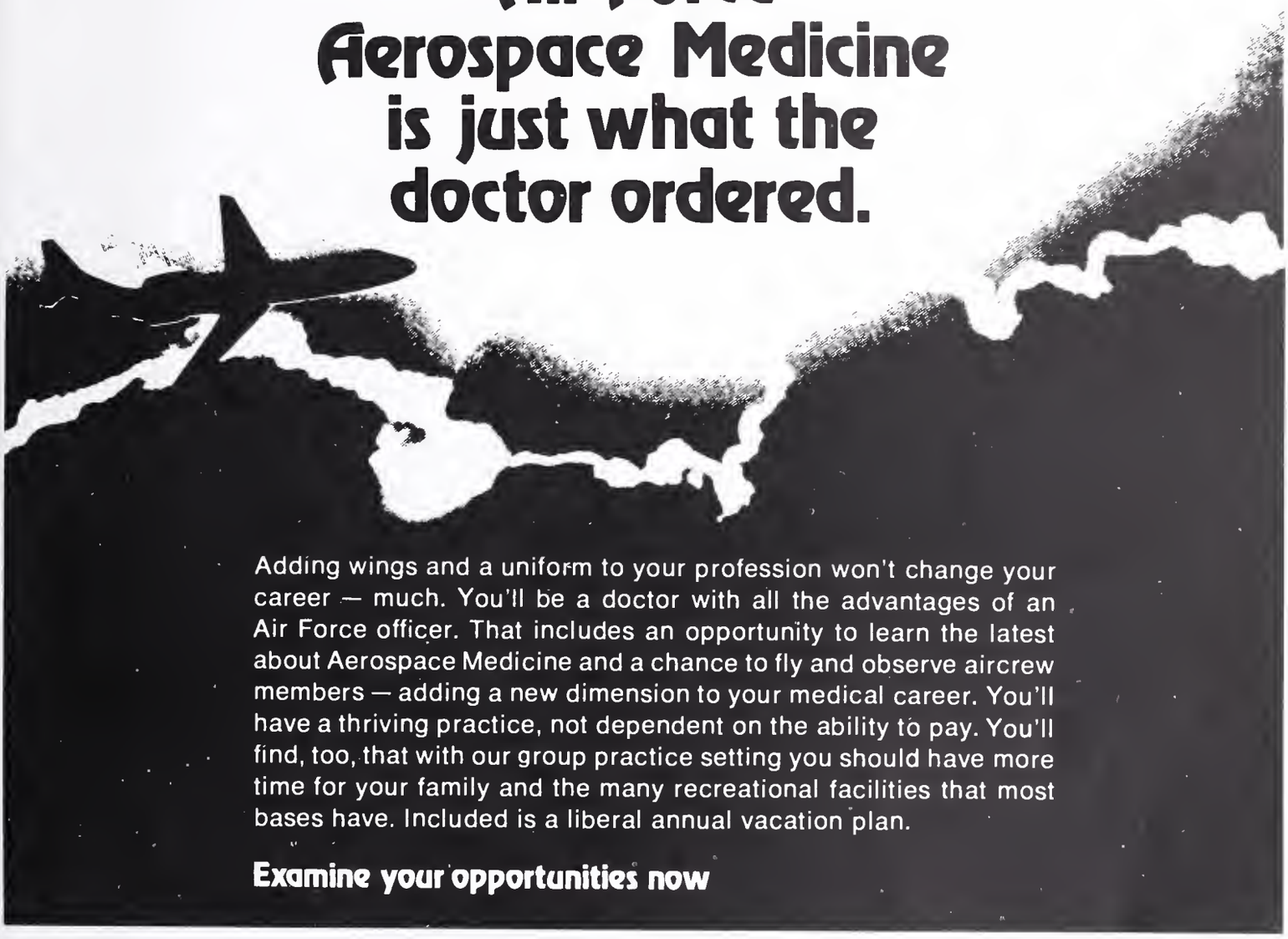
1977 CLINICAL NUTRITION UPDATE SYMPOSIUM: May 16-17; Akron City Hospital, Akron; sponsor: Akron City Hospital; 13 credit hours; contact: Linda Kerlee, Medical Staff Secy., Akron City Hospital, 525 East Market St., Akron 44309, phone: 216/375-3000.



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COLLEAGUES IN THE NEWS . . .

JOSEPHINE BROWN, M.D., New London, has been named the 1977 chief of staff for the New London Hospital. Dr. Brown is an anesthesiologist. **MKILOS EGYED, M.D.,** is the retiring chief of staff.

The American College of Physicians (ACP), national medical specialty society representing internists and specialists in related fields, has elected the following physicians to fellowship in the College: **RONALD M. BUKOWSHIK, M.D.,** Cleveland; **KARL W. KITZMILLER, M.D.,** Cincinnati; **DON E. SANDO, M.D.,** Dayton; **DONALD M. SHAPIRO, M.D.,** Dayton; and **PHILIP VLASTARIS, M.D.,** Fairview Park.

The 36,000-member ACP dedicates itself to upgrading medical care, teaching, and research through stringent membership requirements and programs of continuing medical education. It was the first medical group to offer periodic self-assessment examinations to physicians. **RICHARD W. VILTER, M.D.,** Cincinnati, is Secretary-General of the College.

LARRY C. CAREY, M.D., Columbus, recently became Secretary of the Society for Surgery of the Alimentary Tract. Professor and Chairman of the Department of Surgery of the Ohio State University College of Medicine, Dr. Carey has also been elected to the Board of Directors of the American Board of Surgery.

WALTER A. DANIEL, M.D., Tiffin, has been appointed to the Governing Board of Mercy Hospital. President of the hospital staff in 1960, 1961, and 1976, Dr. Daniel is a Fellow of the American Academy of Family Physicians and the American Society of Abdominal Surgeons. He is also a member of the AMA, the OSMA, and the Seneca County Medical Association as well as the Ohio Academy of General Practitioners.

HARRIET P. DUSTAN, M.D., Cleveland is the new president of the American Heart Association. Dr. Dustan is vice chairman of the Cleveland Clinic's research division and is an authority on hypertension.

H. DAVID EVANS, M.D., Salem, was elected president of the medical staff of the Northern Columbiana County Community Hospital at its recent annual meeting. Other officers include: **F. V. APICELLA, M.D.,** Salem, vice president; **O. E. BUDDE, M.D.,** Salem, secretary-treasurer; and **W. A. BACON, M.D.,** Lisbon, chief of staff.

It was erroneously reported in two recent issues that Howard B. Weaver, M.D., Canton, is president of the Stark County Medical Society. *The Journal* regrets the error.

RAY W. GIFFORD, M.D., head of the Department of Hypertension and Nephrology at the Cleveland Clinic, was installed as president of the Interstate Postgraduate Medical Association of North America at its 61st assembly in Atlanta, Georgia.

ROGER GOVE, M.D., a psychiatrist at the Athens Mental Health and Mental Retardation Center, has been honored by the Professional Association for Retardation in Ohio. Dr. Gove received a plaque for his "outstanding contribution to the field of mental retardation and developmental disabilities." He has 34 years of public service, having joined the Department of Mental Health and Mental Retardation in 1942. Dr. Gove is a former commissioner of the Division of Developmental Disabilities, superintendent of Columbus State Institute, and head of the Youth Commission's Child Study Center.

The Stark County Medical Society has installed **BRIAN S. HARROLD, M.D.,** Massillon City Hospital pathologist, as the 75th president of the Society. **REICH L. WATTERSON, M.D.,** a Canton pediatrician, was named president-elect. Honored at the annual meeting dinner of the Society was **MAURICE F. LIEBER, M.D.,** Canton surgeon. Dr. Lieber has retired from active practice and moved to Florida. He is the Immediate Past President of the OSMA.

WALTER M. HAYNES, M.D., Upper Arlington, was reelected president of the Columbus Bureau of Medical Economics, also known as the Medical Bureau. Other elected officers include **J. RICHARD BRIGGS, M.D.,** Columbus, secretary-treasurer.

ROBERT J. HRITZO, M.D., Youngstown has been elected president of the medical staff of St. Elizabeth Hospital Medical Center. He has been a surgeon on the staff since 1962. Other new officers include: **LOUIS J. GASSER, M.D.,** vice president; **WILLIAM CRAWFORD, M.D.,** secretary-treasurer; **DOCTORS RASHID A. ABDU, JOSEPH V. NEWSON,** and **C. EDWARD PICHETTE,** executive committee; and **SAMUEL D. GOLDBERT, M.D.,** representative of Associated Hospital Services.

ALBERT B. HUFFER, M.D., West Milton, is the new Chief of Staff of Good Samaritan Hospital and Health Center, Dayton. Formerly Chief of the Department of Surgery, Dr. Huffer has practiced in Dayton since 1956. He is Associate Clinical Professor of Surgery at Wright State University School of Medicine. Also assuming duties are **LEONARD KRITZER, M.D.,** chief of staff-elect; **BERKLEY SLUTZKER, M.D.,** representative to the joint conference committee; and **HOWARD ABROMS, M.D.,** secretary.

BURTON A. KASSEL, M.D., Medina, has been elected Chief of Staff of Medina Community Hospital. A general practitioner in Medina County for 18 years, Dr. Kassel is a member of the OSMA, the AMA, and the American Academy of General Practice.

LEO LUTWAK, M.D., Ph.D., recently appointed Chairman of the Department of Medicine at Akron City Hospital, has been named Professor and Program Chief of Nutritional Sciences for Northeastern Ohio Universities College of Medicine. Dr. Lutwak came to Akron City Hospital from Los Angeles, where he held the position of Professor of Medicine at the University of California School of Medicine, Professor of Nutrition at the University of California School of Public Health, and Chief of the Division of Metabolism and Nutrition at the Veterans Administration Hospital, Sepulveda, California. Of his many research interests, his most recent research deals with the effect of calcium and fluoride on bone demineralization, and changing dietary patterns and their effect on disease.

DONALD E. MILLER, M.D., Cincinnati, and **FREDERICK P. ZUSPAN, M.D.,** Columbus, were recipients of Alumni Achievement Awards presented during reunion ceremonies at the Ohio State University College of Medicine. Dr. Miller, a family practitioner in Madisonville, is a member of the OSU Class of 1951. Dr. Miller, a man of diverse interests, raises thoroughbred horses and owns and operates the SchoolHouse Restaurant in Camp Dennison.

Dr. Zuspan, Professor and Chairman of OSU's Department of Obstetrics and Gynecology, is Director and Examiner for the American Board of Obstetrics and Gynecology, President of the American Academy of Reproductive Medicine, and Past President of the Barren Foundation. Also a member of the OSU Class of 1951, Dr. Zuspan is a former president of the Association of Professors of Gynecology and Obstetrics and is a member of the American Board of Pediatrics. Additionally, he is Obstetrician-Gynecologist-in-Chief of Univ.

CARL A. MINNING, M.D., a family physician in Batavia, was awarded the Daniel Drake Award during ceremonies held recently at the Cincinnati Academy of Medicine. The award is presented by the Southeast Ohio Society of Family Physicians to an outstanding family physician. However, only nine such awards have been given since 1948, and Dr. Minning was the first to receive it since 1972. In addition to his medical practice, Dr. Minning served for four years on the Williamsburg Village Council during which time he was instrumental in forming the volunteer fire department. He also aided in establishing a hospital in Clermont.

J. RYLAND MUNDIE, M.D., Dayton, has been appointed Associate Professor in the Department of Community Medicine at Wright State University School of Medicine. Associated with the Aerospace Medical Research Laboratory at Wright-Patterson Air Force Base since 1959, most recently as Chief of the Neurophysiology Branch, Dr. Mundie has conducted research in basic and early exploratory considerations of hearing and speech.

LEONARD PRITCHARD, M.D., Columbiana, has been elected to the nominating committee of the medical staff of Northern Columbiana County Community Hospital. Dr. Pritchard was also reelected as chief of surgery for the 1977 year.

RUSSELL P. RIZZO, M.D., Lakewood, has been elected to the Board of Overseers of Case Western Reserve University. He will represent the School of Medicine alumni on the board, which reviews the university's academic programs and makes recommendations for change and improvement in academic areas. Dr. Rizzo has been Chief of the Orthopedic Department at St. John Hospital since 1951.

ROBERT SECREST, M.D., West Lafayette, has accepted the position of county health commissioner. A family practitioner, Dr. Secrest is also county coroner. Currently Chief of Obstetrics at Coshocton County Memorial Hospital, he is a member of the AMA, the OSMA, the American Academy of Family Physicians, and is a past president of the Coshocton County Medical Society.

BRADFORD T. STOKES, M.D., Assistant Professor in the Department of Physiology at The Ohio State University College of Medicine, is the recent recipient of an $8,716 grant from the Muscular Dystrophy Association of America. This grant brings his total award to $19,000 for a two-year period. Dr. Stokes is examining the possibilities of early neural deficits in the spinal cord of a species genetically susceptible to muscular dystrophy.

A. L. WANNER, M.D., chief of psychiatry, neurology and neurosurgery at the Ohio Valley Medical Center, has been elected president of the center's medical- dental staff. Dr. Wanner is certified by the American Board of Psychiatry and Neurology. President-elect is **M. L. KIRKLAND, M.D.,** a surgeon associated with the St. Clairsville Clinic. **F. L. GIUSTINI, M.D.,** past chairman of the department of obstetrics and gynecology at the center, is the new secretary. Dr. Guistini is a Fellow of the American College of Obstetrics and Gynecology as well as the American College of Surgeons.

JEROME F. WIOT, M.D., Professor and Director of the Department of Radiology at the University of Cincinnati College of Medicine, has been elected to a six-year term on the Board of Trustees of the American Board of Radiology after nomination by the American College of Radiology. The 19-member board is composed of leading radiologists from all over the United States, and membership is considered a top honor in the profession.

JOSEPH P. YUT, M.D., Canton, has been installed as president of the Aultman Hospital Medical Staff. Dr. Yut has been a member of Aultman's active staff since 1968. Other officers include: **WILLARD J. HOWLAND, M.D.,** president-elect; **JOHN J. DOBKINS, M.D.,** secretary-treasurer; **JOHN BUCUR, M.D.,** member-at-large of the Medical Policy Board; and **MURRAY M. BETT, M.D.,** Credentials Committee chairman.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Mentally Ill Commitment Hearing Deadline Extended

The General Assembly enacted and the Governor signed a bill extending the deadline for reviewing the status of mentally ill persons who were indeterminately hospitalized before August 26, 1976. This review was mandated in House Bill 244 enacted last session. The sponsor of H.B. 244, Representative Paul Leonard (D-Dayton), offered H.B. 164 extending the hearing deadline to August 1, 1977.

This extension enables the General Assembly and those involved in the treatment of mentally ill persons to resolve the problems in H.B. 244. The OSMA Department of State Legislation is working with Representative Leonard and other interested groups to revise this legislation.

Informed Consent Legislation

A bill to delete the statutory informed consent form included in last year's Medical Malpractice Act was introduced by Assistant Minority Leader Norman Murdock (R-Cincinnati) and House Judiciary Chairman Harry Lehman (D-Cleveland).

While last year's malpractice law did not mandate the use of the statutory form, it did create a presumption of validity of a form that met certain requirements. Unfortunately, the statutory form has been found to be impractical in many applications and inappropriate in others. H.B. 213, Murdock (R-Cincinnati), deletes the statutory form and eliminates the "laundry list" of adverse reactions that presently are included in a consent form drafted to achieve the statutory presumption of validity.

The bill eliminates any potential liability for a hospital if a physician fails to get a valid consent prior to undertaking a medical or surgical procedure. Neither the original malpractice bill nor this revision alters the physician's responsibility to discuss with the patient the risks and benefits of proposed surgery. This bill makes clear that consent to a procedure is the physician's responsibility.

Generic Drug Substitution

Legislation has been introduced and referred to repeal Ohio's drug anti-substitution laws permitting pharmacists to substitute a so-called "generically equivalent drug" for the brand name drug prescribed for the patient.

Senate Bill 45 (Freeman, D-Canton) and House Bill 151 (Orlett, D-Dayton) are identical initiatives of the Ohio Pharmaceutical Association. Pharmacists claim that substitution will permit cost savings without loss of quality, but there is no discussion of bio- or therapeutic equivalency in the legislation.

OSMA members should be aware that some pharmacies are soliciting physician signatures on forms that will permit pharmacies to substitute generic drugs for the prescribed drug even before the bill becomes law.

The OSMA is opposed to the legislation in its present form. *The Department of State Legislation is interested in your opinion on this issue.*

Use of Diagnostic Drugs By Optometrists

The Ohio Optometric Association will be introducing legislation to redefine the practice of optometry and allow optometrists to use diagnostic drugs. This legislation is part of a national campaign by optometrists to expand the practice of optometry and to gain statutory permission to use diagnostic drugs. Last year the optometrists told the Legislature they had no desire to use diagnostic drugs, but this year the use of diagnostic drugs is in the legislation.

M.D. Jury Duty Exemption

A bill (H.B. 267) to amend Ohio's jury duty exemption statute has been introduced by Representative Harry Lehman (D-Cleveland). The current physician exemption from jury duty is revised so that a physician will receive an exemption on written request. House Bill 267 does not establish any criteria to qualify for an exemption other than the individual be a physician.

Definition of Death

Legislation defining death (HB 298) has been introduced by Representative Robert Nader (D-Warren) and cosponsored by Representative Scribner Fauver (R-Elyria).

House Bill 298 is identical to last session's House Bill 1112 that both Representatives sponsored.

The Legislative Service Commission (the bill-drafting, research arm of the Legislature) is currently completing a study of various types of definitions of death for a report to the General Assembly.

Medical Malpractice Revisions

A report is currently being prepared by the Governor's Advisory Commission on Malpractice that will contain recommended changes to the Medical Malpractice Act, HB 682, that was enacted by the General Assembly in 1975.

The Commission was established to examine the implementation and operation of HB 682 and develop recommendations for possible legislative action to improve the Medical Malpractice Law.

The Commission is chaired by James L. Henry, M.D., Past President of the OSMA; and serving as a member is George N. Bates, M.D., President of the OSMA.



the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

The American Medical Association's "Comprehensive Health Insurance Act of 1977" has been introduced in Congress by four key lawmakers representing both political parties.

AMA President Richard E. Palmer, M.D., has urged the 95th Congress and President Carter to give serious consideration to "this forthright approach to national health insurance (NHI). This bill would extend health insurance to every American at a cost the nation could afford. It is a viable solution to the problem of providing quality health and medical care to everyone."

The legislation, H.R. 1818 and Senate 218, was well-publicized when it was introduced into the Senate by Senator Clifford P. Hansen (R-Wyo.) and in the House by Reps. Tim Lee Carter (R-Ky.), John M. Murphy (D-NY), and John J. Duncan (R-Tenn.).

Senator Hansen, a member of the Senate Finance Committee, said:

> The bill we are introducing today would solve the problem of financing for every American. It would guarantee quality medical care to everybody. It would cover the cost of catastrophic illness. It would be fully comprehensive in terms of benefits. It would build on our present system, rather than dismantling it and replacing it from scratch with a new one requiring the creation of a giant bureaucracy. It would allow everyone to choose his or her own physician, dentist, and health insurance plan. And it would be a plan we can afford.
>
> This legislation would cover the poor by paying all their insurance premiums. Those better able to afford to pay those premiums would be assisted in a fashion commensurate to their need by lesser degrees of government help. The affluent would even be encouraged to buy health insurance by a tax subsidy of 10 percent of the premium cost.
>
> As the principal (Senate) sponsor, I am confident that this measure can meet our needs at a cost, in new dollars, that will not be burdensome.

The medical profession's NHI plan would build on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 percent of the cost. Employees would not be compelled to participate.

The self-employed as well as the non-employed could purchase qualified private health insurance, through pools if needed, at a cost not more than 125 percent of the cost of group plans. They would have all or part of the premium paid for by the federal government depending upon their income tax liability.

Small businesses that found the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would, for the most part, be supplanted under the program.

After a certain level of co-insurance was reached, depending upon income, insurance would cover all remaining expenses as a complete protection against catastrophic costs.

The co-insurance factor would deprive no one of needed care, the sponsors said. The absolute maximum that any individual would have to pay would be $1,500; the absolute maximum for any family would be $2,000 in any given year.

Rep. Carter, ranking minority member of the House Health Subcommittee, said:

> ...As a member of the House Subcommittee on Health and Environment for 12 years, I have devoted much of my legislative effort to issues concerning our country's health-care system. And as a physician, I have made a personal commitment to do what I can to help improve the health care of our people.
>
> As a co-sponsor of the Comprehensive Health Care Insurance Act of 1977, I believe this measure offers a workable approach to extending health insurance to every American. In large measure, this proposal retains the expertise and experience of our existing private health-care sector in both its administration and financing.
>
> It is these proven skills and resources of the private sector which I believe we should build upon in developing a national health insurance program, and which should be supplemented only when necessary by government.
>
> This proposal would provide coverage to the great bulk of the American population through employer-employee financial arrangements in which not less than 65 percent of the premium would be paid by the employer.
>
> For those who are self-employed or unemployed, health insurance would be provided through an income-tax credit or federal certificate of entitlement system. Thus this plan would correct one of the major weaknesses of our present system by removing the financial barriers that in the past have denied some Americans access to high quality care.

Rep. Murphy, with Carter a member of the House Interstate and Foreign Commerce Committee, said the proposed legislation would provide:

> ...More comprehensive benefits than any other (proposal) previously considered by Congress; and it would deliver quality health care to everyone— including the poor and the elderly— without bankrupting the nation.
>
> For those unemployed, or of low or fixed income, and the elderly, premium costs would be paid by the government on an equitable sliding scale.
>
> By building the private sector and helping those who need help the most, this approach avoids many of the problems inherent in other proposals before the Congress.
>
> Further, it would avoid additional burdens on an already beleaguered social security system, the preservation of which must be one of our highest national priorities.

Rep. Duncan, a member of the House Ways and Means Committee, questioning how Congress could write a national health insurance plan while preserving at the same time the fiscal integrity of the Treasury, said in prepared remarks:

> The Comprehensive Health Care Insurance Act of 1977... controls costs by limiting federal help to those in need by determining that level of need from income tax liability. Additional cost controls are found in its co-insurance factor, except for the poor; its provision of preventive care; and its promotion of competition among health insurance carriers.

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Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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1 Russek HI: AM J M Sc 239:478, 1960



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(continued from page 131)
be present in the patient with each attack. Lacrimination with or without conjunctival injection is common. Typically, there is nasal stuffiness and congestion on the ipsilateral side. Rhinorrhea commences as the headache leaves. These symptoms may lead to an erroneous diagnosis of sinus disease. Ptosis and meiosis on the affected side occur quite often. The etiology of this phenomenon was investigated by Kunkle and Anderson in 1960.[6] They concluded that the partial Horner's syndrome occurred because of compression of the sympathetic fibers that lie in the adventitia of the internal carotid artery as the artery dilates on the osseous canal of the skull. Recently, Ekbom has been able to separate cluster headache into upper- and lower-cluster headache syndromes.[7] The upper syndrome of cluster headache is accompanied by pain involving the eye, forehead, and/or temple. Sometimes the pain extends to the neck area. The lower-cluster headache syndrome is characterized by pain in the eye with radiation into the infraorbital region or jaw. It is the lower syndrome that is accompanied by the partial Horner's syndrome and lacks visible swelling of the superficial temporal artery. Ekbom suggested the upper syndrome is caused by dilatation of the external carotid artery, while the lower syndrome is characterized primarily by dilatation of the internal carotid artery.

One of the most consistent features of this headache syndrome is its periodicity. The name cluster headache refers to the fact that the attacks of pain occur daily for several weeks or months following which there is a remission with pain-free intervals of several months to several years. Generally, the attacks occur for a period of four to eight weeks and remissions last one to two years, but all variations do occur. For reasons unknown, clusters seem to occur more often in the spring and fall. In recent years, it has been recognized that a small number of patients with typical headaches of the cluster type do not have spontaneous remissions.[8,9] The term chronic migrainous neuralgia has been used to describe the chronic variety of cluster headaches. The attacks are identical to those of periodic cluster headaches except that these persons have had one or more headaches per week for at least one year without any remissions. The incidence of this chronic form seems to be about 10 to 13 percent.

Many patients note that ingestion of alcohol during a period of headaches will induce an attack of pain within minutes, whereas when they are in a period of remission, alcohol — even in large quantities — will not induce pain. Nitroglycerin, likewise, will induce an attack during a period of cluster but not during periods of remission.[10] It also has been noted that males with cluster headache tend to drink more and smoke more.[11-13] Ulcer disease also has been demonstrated to be more prevalent in cluster headache patients than in persons with migraine or in persons without headache.[11,13]

A common factor accounting for the increase in alcohol usage, smoking, and incidence of ulcer disease could be the personality type of the cluster headache patient. Psychologic tests performed on a series of cluster headache patients demonstrated high scores in such traits as conscientiousness, persevering, responsible, self-sufficient, precise, resourceful, tense, frustrated, driven, and overwrought.[12] A more detailed study of a small number of cluster patients demonstrated obsessive, compulsive behavior traits in aggressive, hard-driving, goal-oriented males.[13] These men push themselves until they falter because of the symptoms or until they reach their goals, only to collapse in a siege of headaches.

In 1968, Graham first described similar facial characteristics which he noted in many of his cluster headache patients.[13,14] Since then, others have noted that these facial characteristics indeed are present and that many men with cluster headache look very much alike. These traits also are present in women who have cluster headaches. The term leonine has been used to describe these facial characteristics. Typically, there is a ruddy complexion due to the high hematocrit that often is present. The skin is thickened, coarse, and deeply pitted. Prominent furrows on the forehead with vertical creases at the glabella are common. The chin is square-cut with dimpling and thick, coarse skin. Deep nasial-labial folds are prominent.

Beneath this external manly and strong-appearing face of the aggressive, hard-driving male often lie great dependency needs. This dependency has been noted in the previous studies on psychologic traits in cluster headache.[13,14] It has been noted by others and myself that the wife or mother usually calls when the headaches return. The wife makes the appointment or brings the patient into the physician's office and takes the prescription from the physician. It seems these men can't admit that something as "simple as a headache" can cause them to be so incapacitated. They feel ashamed, guilty, and inadequate.

Cluster and Migraine

There is much debate as to whether cluster and migraine headaches are closely related and are variants of the same condition or whether they are, in reality, separate entities. Similar features of both are the unilaterality of pain, the psychologic traits, the accompanying phenomenon, similar provocative factors, and reactions to similar drugs. Characteristics that are different in the two states include the sexual incidence, lack of heredity in cluster headache, the clear-cut periods of remission in cluster, the duration of pain, and the lack of prodromal symptoms in cluster headache. I feel the evidence supporting the idea that they are separate conditions is strong. This opinion seems to be gaining support because of recent biochemical and vascular studies which have shown distinct differences in the two conditions.

Although it has been well demonstrated that plasma serotonin decreases and its metabolites increase in the urine at the onset of migraine, such changes have not been demonstrated to occur in cluster headache.[15] Furthermore, whole-blood histamine levels increase during the cluster headache attacks, whereas there is no significant increase of histamine during the migraine attack.[15]

Sjaastad's group in Oslo, by using dynamic tonometry, has been able to consistently show increased pulse amplitudes in the eye on the symptomatic side during attacks of pain in cluster headache. These changes have not been found in persons during migraine attacks.[16] Thermography has shown increased temperature on the symptomatic side during an attack of cluster and decreased temperature during migraine, indicating constriction of cutaneous capillaries in the latter.[17]

Etiology

The etiology of cluster headaches, and migraine for that matter, is not known. Most agree that the pain is due to dilation of various areas of the carotid system including the internal carotid, which accounts for the retro-orbital aspect of pain and the ocular sympathetic paresis.[6,18] Horton felt that histamine released locally was the cause of the vasodilatation because he could provoke attacks with histamine, and histamine desensitization seemed to bring relief.[3] As mentioned previously, other agents such as alcohol and nitroglycerin will provoke an attack, as well as histamine.[10] Most everyone no longer considers histamine sensitivity to be an etiologic factor. Abnormal efferent-nerve impulses causing vascular dilation have been considered as an etiologic factor and have led to various surgical procedures in an effort to control the painful attacks.[9,19,20] Kunkle found acetylcholine-like activity in the cerebral spinal fluid of four patients with cluster headache and postulated that this might be related to the vasodilating agent responsible for vascular head aches.[21]

Therapy for Cluster Headache

The therapy for cluster headache is essentially pharmaceutical. The three most useful drugs are methysergide, ergotamine, and corticosteroids. Most cluster headaches can be shortened or controlled with these drugs singly or in combination. Methysergide* is my preference as initial therapy. Usually, a daily dose of four tablets (2 mg) a day is needed. If no improvement occurs in one week, I will add corticosteroids to the methysergide therapy. I usually add prednisone, but triamcinolone or methyl prednisolone may be used. If the methysergide and steroid combination is not effective, then ergotamine tartrate (1 mg) is used four times daily in a regular dose, along with steroids. Others prefer to start with the steroid-ergotamine combination. Other medications such as propranolol,† indomethacin,‡ tranquilizers, and antidepressants may help occasionally. Of course, most cluster headaches will end sooner or later without any medical treament. This makes the evaluation of effective therapy quite difficult. Very few persons still use the histamine desensitization program which is inconvenient, difficult to use, and does not prevent recurrence of clusters.

Since these headaches hit so suddenly and are of such short duration, the basis of treatment should be prophylactic. Ergotamine taken at the onset of the headache may help, but often it doesn't and narcotics may be needed. I usually don't hesitate to use narcotics in the usual case of cluster headache because they will be needed for only a short period of time.

As mentioned earlier, there is a small number of unfortunate persons who have the chronic state of cluster headache. These miserable persons often are completely disabled by the frequent attacks. They are medical failures. Past surgical attempts at relief almost always have been followed by recurrence of attacks. In the past few years, one of my neurosurgical colleagues has performed surgery, using the combined procedure of section of the greater superficial petrosal nerve and the neurolysis of the trigeminal nerve, in an attempt to bring pain relief to these chronic cases.[9] Our results have not been great, but these people are willing to do anything in hopes of getting some relief. Fourteen patients have been operated on. Of these, three have had no recurrence; five have had remissions of several months only to be followed by a recurrence of attacks; three had a very short remission; and three had no benefit whatsoever. It is interesting that in five of those who had postoperative recurrences, medical therapy, which had failed to control the attacks previously, was successful in inducing a remission.

Summary

Cluster headache is a well-defined clinical syndrome consisting of episodes of severe, unilateral, head pain occurring in a cluster pattern. Although the condition is of a vascular nature, its etiology is unknown. Medical treatment usually is effective, but surgical procedures may be worthwhile occasionally. It is hoped that this syndrome, which often is not correctly diagnosed, will be easier recognized by the practitioner and, thus, the sufferers will have the benefit of the effective therapy that is available.

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(continued on page 138)

*Methysergide maleate — Sansert (Sandoz Pharmaceuticals)
†Propranolol hydrochloride — Inderal (Ayerst Laboratories)
‡Indomethacin — Indocin (Merck Sharp & Dohme)

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Obstetric Anesthesiology Practices and Attitudes in Hospitals in Cuyahoga County, Ohio: A Survey

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This report summarizes the results of a series of surveys in Cuyahoga County, Ohio. The surveys requested census figures, attitudes, and perceptions of hospital administrators, directors of departments of anesthesia, anesthesiologists, and obstetricians regarding anesthesia practices in obstetrics. A comparison of some of the survey data is made with the results of a nationwide survey conducted by the American College of Obstetricians and Gynecologists. Attitudes regarding the use of anesthesiologist's assistants are discussed also.

A SURVEY CONDUCTED in Cuyahoga County, Ohio area hospitals addressed the following issues: (1) current practices in obstetric anesthesia in Cuyahoga County; (2) perceptions of administrative anesthesiologists concerning the effects of using anesthesiologists' assistants in obstetrics; and (3) attitudes of practicing anesthesiologists and obstetricians regarding their individual involvement in obstetric anesthesia.

The census of obstetric anesthesia practices was compiled through questionnaires sent to hospital administrators and to directors of departments of anesthesiology of the 20 hospitals* participating in the study. The directors also submitted their perceptions pertaining to the employability of a new category of professionals — the anesthesiologist's assistant — currently being trained at Case Western Reserve University (CWRU).[1] Anesthesiologists and obstetricians practicing in Northeast Ohio were queried† regarding their background and their involvement in obstetric anesthesiology and regarding their attitudes toward the practice.*

Since certain questions were pertinent to only a subgroup of the population of obstetric anesthesia personnel, separate questionnaires were formulated and tailored for each of four audiences: hospital administrators, directors of departments of anesthesia, anesthesiologists, and obstetricians.

Data obtained from these questionnaires then were analyzed statistically within and across the respective questionnaire sets, and the results are summarized in the remainder of this article. Moreover, some of the results are compared to a report on a national survey conducted by the American College of Obstetricians and Gynecologists (ACOG).[2]

Upon request, the detailed results of the survey are available in a technical memorandum.[3]

Hospital Administrators

The questionnaire sent to the administrators of 20 hospitals in this study requested statistics on the numbers of cesarean sections performed and vaginal deliveries completed in each of the past five years and on equipment and facilities available. Two questions concerned changes expected in obstetrical ward sizes and in the number of deliveries to be handled by the hospital through 1980.

The responding hospitals were categorized according

*Hospitals: Bay View, Bedford Municipal, Booth Memorial, Brentwood, Cuyahoga County, Deaconess, Euclid General, Fairview General, Forest City, Grace, Hillcrest, Marymount, Mount Sinai, Parma Community General, St. Alexis, St. Ann, St. John's, St. Luke's, University, and Woman's General.

†Under the sponsorship of the Ohio Society of Anesthesiologists and the Ohio Section of the American College of Obstetricians and Gynecologists, respectively.

*Based on several discussions with the Ohio Society of Nurse Anesthetists (OSNA), we had reason to assume that the questionnaire prepared would be included as part of a statewide survey conducted by OSNA. However, none of the questions submitted to them was included. We have since learned that only about five nurse anesthetists within the 20 hospitals participating in the CWRU survey devote most of their time to obstetrics. Therefore, work characteristics and attitudes of nurse anesthetists in and toward obstetric anesthesia administration is not discussed in this report.

to ownership, availability of a teaching program, and number of deliveries per year.

Of the 20 participating hospitals, 70 percent were private (not government sponsored) and 35 percent had a teaching program (resident and/or intern teaching program in effect). Fifty percent of the hospitals were classified as private and as having a large obstetric service (1,000 or more annual deliveries).

Types of Delivery.— The 20 respondents reported 28,507 deliveries in the county for 1971 of which 7.7 percent were cesarean sections. The total number of cesarean-section deliveries increased steadily in the five years preceding 1972, while a decline was seen in the number of reported vaginal deliveries.

Responding to the query concerning their perceptions of any birth rate change in Greater Cleveland, five of the hospital administrators projected an increase in the number of deliveries, eight projected a decrease, and seven projected no change.

Hospitals in the survey who had fewer than 400 deliveries annually are tending to discontinue their obstetric services. Three of these low-activity services have done so already, and 50 percent of the remaining hospitals in this category may phase out their obstetric wards before 1980.

Twenty-five percent of all reported obstetric patients were staff patients (those not paying for services rendered). Likewise, in the six large teaching hospitals, the ratio of staff to private patient was 1:4.

Use of Facilities.— The use of labor room beds and delivery rooms for all hospitals is summarized in the Table.

The Committee on Professional Standards of the American College of Obstetricians and Gynecologists (ACOG)[2] has suggested that a reasonable number of annual births per labor bed should be 250. A high variation was found in individual hospital utilizations, with the mean number of births per labor bed being 195. Only the group having 2,000 or more deliveries per year, or 25 percent of the sampled hospitals, maintained the suggested level of utilization.

The Committee also suggested that a reasonable number of annual births per delivery room should be 500. The mean number of annual births per delivery room of the hospitals in this survey was 528. Sixty percent of the hospitals participating in the study attained the recommended utilization. Four of the hospitals, all reporting more than 1,000 births per year, indicated a delivery room usage of 700 to 1,000 annual births per delivery room. Such hospitals must concern themselves with the possibilities of over-utilization and related problems.

Thirty percent of the hospitals in the study reported having no recovery area reserved for obstetric patients. Fifty percent of these used the labor room for recovery and observation of obstetric patients. Thirty-three percent used the patients' rooms for recovery, while 17 percent made use of the delivery room itself for this procedure.

Number and Use of Obstetric Facilities

Facility	No.	Average No. Per Hospital	Average Births Per Unit Facility
Labor beds	146	7.3	195
Delivery room	54	2.7	528

Directors of Departments of Anesthesia

A second questionnaire was mailed to the anesthesia department directors of the 20 hospitals. It dealt with the number and availability of professional personnel in obstetrics, the choice and administration of various anesthetics, and the care of the newborn infant.

Professional Personnel in Obstetrics.— Personnel involved in obstetric anesthesia were classified according to four groups: (A) board-qualified anesthesiologists; (B) obstetricians; (C) nurse anesthetists and anesthesia house staff; and (D) nurses and other house staff. House staff includes residents, interns, and students.

The responding directors indicated, as would be expected, that the average number of personnel in each of the four occupational classifications increases as the size of obstetric service increases. Of importance is the limited involvement of the nurse anesthetist and anesthesia house staff. Only three hospitals reported the use of a nurse anesthetist in obstetrics, and each indicated that the nurse anesthetist had minor responsibility. This is contrasted with anesthesiologists reported as comprising the majority of the obstetric anesthesia personnel, even among the hospitals performing fewer than 400 deliveries per year.

The current mix of manpower apparently is not what is desired though. Responding directors from hospitals reporting more than 1,000 annual births desired a

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Submitted August 31, 1976.

decrease (from 6.2 to 2.7) in the average number of anesthesiologists for their obstetric service, coupled with a simultaneous increase (from 3.4 to 3.8) in the average number of nurse anesthetists.

All respondents representing obstetric services of less than 400 births per year desired anethesiologists to be the only administrators of obstetric anesthesia.

Directors of anesthesiology of hospitals reporting more than 2,000 deliveries per year desired anesthesiologists to comprise only one-fourth of the obstetric anesthesia personnel, rather than nearly one-half as is the current situation.

Sixty-nine percent of all obstetric services represented in the survey had an anesthesiologist available at the hospital at all times. Furthermore, 95 percent of the respondents reported that at least one anesthesiologist was available within 20 minutes of notification.

As this questionnaire was being formulated, the then current status of the project was presented to the Cleveland Committee on Anesthesia Manpower.[4] It was their feeling that perceptions regarding the use of anesthesiologists' assistants should be solicited from directors of departments of anesthesia. Personnel, after receiving a bachelor of science degree in health services,[5] would aid in the administration of anesthesia under the supervision of an anesthesiologist. The use of such personnel may create changes concerning both the efficiency of anesthesia administration and efficacy to the patient. Some of the projections of various changes by the responding directors were:

The perception of 31 percent of all responding directors was that if anesthesiologists' assistants were employed in obstetric anesthesia, cost to the obstetric patient would increase.

Of the 38 percent of the respondents who believe the quality of patient care would be changed, one-half indicated that this quality would be increased. Nearly two-thirds indicated a drastic decrease in the anesthesiologists' workload.

Thirty-one percent of the respondents believed the income of obstetric anesthesiologists would change. Four-fifths of them projected a decrease in income.

Use of Anesthetics.— More than 80 percent of the obstetric patients in each hospital participating in the study received anesthesia during delivery. Eighty percent of the respondents reported spinal anesthesia was used primarily for both vaginal deliveries and cesarean sections. The larger the obstetric ward, the greater the use of spinal anesthesia and the less the use of general anesthesia.

Most often, the anesthesiologist selected both the anesthetic and the personnel to administer it, and he or she was the most frequent administrant of this anesthetic. One third of the respondents from teaching hospitals reported the sharing of that responsibility with resident anesthesiologists. Other categories of personnel were not indicated as having a major part in anesthesia administration by any of the hospitals. Eighty percent of the regional blocks were performed by obstetricians.

Care of the Infant.— At the time of the delivery, an initial examination of the newborn infant is made by obstetric personnel. According to 63 percent of the responding directors, the obstetrician usually performs this examination. Immediate care, including resuscitation, for the newborn infant in distress was provided by anesthesiology personnel, according to 69 percent of the respondents. One half of the total reported deliveries were performed in hospitals recording fewer than 2,000 annual births, and in 92 percent of these hospitals, the initial examination was preliminary to a later final examination. The larger the obstetric service, the more frequently the initial examination of the newborn infant was reported as complete rather than preliminary.

Two-thirds of the responding directors indicated that the delivery room nurse was the usual observer of the patients during the first hour after the delivery.

Anesthesiologists

Anesthesiologists practicing in hospitals located in Cuyahoga County were queried regarding their current involvement with obstetric anesthesia, their medical school background, and their attitudes regarding obstetric anesthesia in general. The mailing list and cover letter were supplied by Henry E. Kretchmer, M.D., President of the Ohio Society of Anesthesiologists at the time this study was made. He also was a member of the Cleveland Committee on Anesthesia Manpower.

Eighty-six anesthesiologists, or 52 percent of the mailing list, responded to the questionnaire. Not all anesthesiologists to whom the questionnaire was mailed were involved in obstetrics, and a sizable percent of the addressees, having been in residency programs, had moved away from the Cleveland area.

Time Spent in Obstetrics.— One fourth of all responding anesthesiologists were not involved with obstetric anesthesia. Ninety percent of the respondents who are involved in obstetrics spend less than 25 percent of their time in that capacity. Three of them spend more than half their time in obstetrics.

A recent report to the Committee on Manpower of the American Society of Anesthesiologists (ASA),[6] discussing the 1974 ASA membership survey, revealed that 5 percent of the average (national) anesthesiologist's time is spent personally administering anesthetics in obstetrics. On this basis, the authors calculate 541 full-time equivalent (5 percent of 10,814 clinically active in the USA) anesthesiologists in obstetrics.

Medical School Background.— The countries where the respondents received their medical education were grouped into five regions: USA (and Canada), Asia Europe, Latin and South America, and Africa. Asia included the Middle East, India, and the Far East. The distribution of the respondents' "countries of origin" revealed that 55 percent of them received their medical

school training outside the USA (half of whom received their training in Asia).

A possible variable distinguishing various attitudes within the profession may be the number of years in practice. A surrogate for this measure was the number of years since graduation from a medical school. Thus classified, 44 percent of the respondents graduated from medical school between 11 and 20 years ago. Eighty-two percent of all respondents completed this schooling more than ten years ago.

Forty percent of those respondents who were ten or less years from graduation spend zero (0) percent of their time in obstetrics. This proportion of respondents decreases as the time since graduation lengthens. All those who graduated more than 30 years ago spent between 1 and 25 percent of their time in obstetrics.

Hospitals with which 50 percent of the respondents were associated are classified as private, teaching, and those having large obstetric services.

Attitudes.— About 9 percent of the responding physicians believed that uncomplicated, normal, vaginal deliveries usually are best managed *without* major anesthesia.

Of the four major categories of anesthesia, namely, inhalation (not self-administered), spinal, caudal, and epidural (lumbar), spinal anesthesia was preferred for both vaginal deliveries and cesarean sections by more than 80 percent of the respondents. Eleven percent of the directors of departments of anesthesia indicated that residents usually administered the anesthesia.

Subjective viewpoints were further sought concerning the quality of anesthesia facilities and equipment used in obstetric services as compared to the quality of similar facilities used in surgical anesthia in the respective hospitals. No respondents indicated that the facilities and equipment used in obstetric anesthesia were of better quality than those used in surgery, and 26 percent considered the obstetric facilities and equipment to be worse. Interestingly, those respondents *not* involved in obstetrics rated the obstetric facility and equipment quality lower than that used in surgery more frequently than those who did work in obstetrics. Seventy-nine percent of the respondents who dedicated some time to obstetrics considered the facility and equipment quality of that department the same or similar to equipment used for surgical anesthesia.

Respondents graduating from Asian medical schools and those who graduated from medical school 31 or more years ago, more often regarded obstetric anesthesia equipment to be similar in quality to that used in surgical anesthesia.

Anesthesiologists participating in the survey were asked two questions regarding personnel in obstetric anesthesia. The first concerned the respondents' perceptions of the necessity of the presence of the anesthesiologist during the administration of the anesthetic; the second considered compatibility with the obstetrician.

Approximately 84 percent of all respondents believed the anesthesiologist should be present if anesthesia is to be administered in obstetrics. More than twice as many US-trained as foreign-trained anesthesiologists believed their presence was *not* always required during the administration of the anesthetic.

All of the respondents graduating ten or fewer years ago believed the anesthesiologist's presence should be required, while 80 percent who graduated more than ten years ago felt the same.

Twenty-two percent of all respondents and 28 percent of those not involved in obstetrics considered working with an obstetrician more difficult than working with a surgeon. The greater the number of years since graduation from medical school, the less the difficulty reported in working with an obstetrician as opposed to a surgeon.

More than 30 percent of the respondents believed they were unable to charge fees in obstetrics comparable to those charged in surgery. Again, the fewer the number of years since graduation from medical school, the less able the respondents felt to charge adequate fees. The average desired increase in income to correct this disparity was 40 percent.

Over 57 percent of all respondents considered obstetric anesthesia as challenging and/or as professionally rewarding as surgical anesthesia, but only 13 percent preferred to perform in obstetrics.

Obstetricians

In order to compare the perceptions of the two audiences, obstetricians in the region were sent basically the same questions as those asked of the anesthesiologists. The mailing list was obtained from the Cleveland Academy of Medicine, and Richard J. Nowak, M.D., President of the Cleveland Society of Obstetricians and Gynecologists at the time the survey was conducted, signed the cover letter. Of the 197 obstetricians practicing in the region, 129, or 66 percent, responded to the questionnaire.

Responses of the obstetricians are presented in two sections; their background and involvement classifications and their attitudes toward anesthesia administration and toward other anesthesia personnel in obstetrics.

Classifications.— Involvement in obstetrics was defined in terms of the number of deliveries performed per year, participation in group practice, and hospital association. Each physician was further asked to identify the country in which he or she attended medical school, along with the year of graduation. More than half of the respondents performed more than 150 deliveries annually, while 12 percent had more than 300 deliveries. Thirty percent of the responding obstetricians indicated that they participate in a group practice.

Eighty-five percent of the respondents were affiliated with privately owned institutions, 53 percent with nonteaching institutions, and 88 percent worked in large obstetric services.

Nearly three-fourths of the respondents attended medical schools in the United States. Of those trained in foreign countries, two-thirds indicated European or

Canadian medical schools. Almost all of them who had completed postgraduate work had done so in the United States.

Ninety-two percent of the respondents graduated from medical school more than ten years ago.

It was discovered that, generally, the greater the number of years since graduation from medical school, the more deliveries the respondent performs per year. Fifty-five percent of the respondents who had graduated within the past ten years reported fewer than 75 annual births, while 55 percent of those who were 21 or more years away from graduation performed more than 150 deliveries.

Attitudes.— Perceptions were requested of each obstetrician participating in the survey of their views regarding two areas of obstetric anesthesia: the administration of the anesthesia and the involvement with other anesthesia personnel in obstetrics.

About 8 percent of the respondents believed that a normal vaginal delivery could be best managed without major anesthesia. Most of these individuals performed fewer than 150 deliveries annually and graduated 20 or fewer years ago from a medical school in the United States. Spinal anesthesia was preferred most often by all respondents for both vaginal deliveries and cesarean sections — more often by those associated with private rather than with public hospitals and least often by those educated in Europe.

The greater the number of deliveries performed by the responding obstetricians per year, the larger was the percentage of private patients which they served. Those associated with teaching hospitals served a larger percentage of nonstaff patients than did responding physicians from nonteaching hospitals. Nearly all the deliveries performed by respondents from small obstetric services were of private patients.

Less than 3 percent of the respondents indicated that the obstetrician usually provided the major anesthesia for vaginal deliveries. The anesthesiologist was reported to be the usual provider.

An important influence upon the performance of a worker is the relationship to those with whom he or she works. To assess these subjective feelings, the obstetricians were asked if it were easier to work with a nurse anesthetist, an anesthesiologist, or if there were no difference. Three-fourths preferred the anesthesiologist, and 20 percent indicated that it made no difference. All responding obstetricians who attended Asian medical schools considered working with an anesthesiologist easier than with a nurse anesthetist.

Interquestionnaire Analysis. — This section compares the responses of the physicians and administrators participating in the survey of the topics common to several of the four questionnaires. These topics include hospital and patient classifications, the administration of anesthesia, backgrounds of the responding anesthesiologists and obstetricians, and attitudes toward certain areas of anesthesiology in obstetrics.

Hospitals Represented.— On the average, private hospitals have more anesthesiologists, and decidedly more obstetricians, on their staff than do public hospitals participating in the study. Similarly, a higher proportion of responding anesthesiologists practice in teaching than in nonteaching hospitals. Of course, resident anesthesiologists are constrained to practice in the teaching institutions. As would be expected, the bulk of the responding physicians are associated with the hospitals performing the majority of the deliveries.

Patients Represented.— More than 98 percent of the respondents in each of the categories of director of department of anesthesiology, anesthesiologist, and obstetrician reported that at least 50 percent of the obstetric patients in the hospitals received major anesthesia for vaginal deliveries.

Usual Provider of Obstetric Anesthesia.— Eleven percent of the directors of departments of anesthesia and 29 percent of the anesthesiologists believed that resident anesthesiologists were the major providers of this service. Furthermore, 6 percent of the responding anesthesiologists and obstetricians believed that a nurse anesthetist or an obstetrician usually administered this anesthesia.

Anesthetic Usage and Preference.— The percentage of directors who reported that general anesthesia was given most often to vaginal delivery patients in their hospitals was much larger than the percentage of responding anesthesiologists and obstetricians who indicated it to be their first preference. Spinal anesthesia was the most often used and/or preferred by the respondents of all three audiences.

Background of Responding Anesthesiologists and Obstetricians.— More than twice as many responding anesthesiologists as obstetricians attended foreign medical schools. Fifty-three percent of the foreign-trained anesthesiologists attended Asian medical schools, while two-thirds of the foreign-trained obstetricians attended medical schools in Europe or Canada.

The responding anesthesiologists graduated from medical school significantly more recently than did the obstetricians participating in the survey. Specifically, 56 percent of the anesthesiologists graduated less than 20 years ago, while 41 percent of the obstetricians graduated in the same period. At the other end, the proportion of obstetricians with over 30 years of practice is more than double the corresponding figure for anesthesiologists.

Attitudes of Responding Anesthesiologists and Obstetricians.— Nine percent of the anesthesiologists and 8 percent of the obstetricians indicated major anesthesia was not necessary for a normal vaginal delivery. Almost all of these respondents graduated from medical school 20 or fewer years ago and are associated with teaching hospitals

with large (more than 1,000 deliveries annually) obstetric services.

The anesthesiologists and obstetricians also were queried concerning any problems they had in working with members of the other group. The anesthesiologists who attended medical school in the USA recorded the highest incidence (30 percent) of problems of incompatibility when working with an obstetrician. Almost all of the responding obstetricians reported no difficulty in working with an anesthesiologist.

The fewer the number of years since the graduation of the responding anesthesiologist from medical school, the higher the degree of incompatibility in working with an obstetrician. (Ten percent of those graduating more than 30 years ago reported this problem, compared to 30 percent of those graduating in the past ten years.) Responding anesthesiologists from private, teaching, or large obstetric services were noticeable (25 to 30 percent) in reporting some difficulty in working with an obstetrician.

Comparison of Results of Studies by ACOG and CWRU

As indicated earlier, a *national* survey of maternity care was performed by the American College of Obstetricians and Gynecologists (ACOG) in 1968.[2] Since the large sample size of 3,883 responding hospitals in that study was assumed to suppress any possible regional biases, we purposely designed certain questions (directed to hospital administrators and directors of departments of anesthesia) to be similar to those asked by the ACOG. Comparisons between some of the results of the two studies are:

Survey of Hospital Administrators.— Seventy-six percent of the ACOG hospitals in the ACOG study performed fewer than 1,000 annual deliveries, whereas 60 percent of hospitals in the CWRU study reported more than 1,000 births per year.

Sixty percent of the CWRU-study hospitals performed 85.3 percent of all deliveries, and 24.3 percent of hospitals in the ACOG study performed 64 percent of all deliveries, all among services reporting more than 1,000 annual births.

In both studies, the larger the obstetric service (measured in the number of deliveries per year), the greater the proportion of cesarean sections.

Seventy-seven percent of the ACOG-study hospitals serviced mostly (60 to 100 percent) private obstetric patients, while 95 percent of the Cleveland hospitals did so.

In either study, only obstetric services reporting more than 2,000 births per year attained the recommended level of 250 annual births per labor bed.

The Cleveland average of 528 annual births per delivery room was above the suggested level of 500 and well above the national average of 386.

In Cleveland, 70 percent of the hospitals reported having a separate obstetric recovery room, while nationwide, only 30 percent of the respondents indicated thus.

Survey of Directors of Departments of Anesthesia.— Five percent of the CWRU respondents indicated their anesthesiologists were on call at specific times only; this was the case for 43 percent of the nationwide respondents.

Almost all (80 to 100 percent) of the obstetric patients were given anesthesia for delivery according to 82 percent of the ACOG respondents and 100 percent of the hospitals in Cleveland.

Spinal anesthesia was used most often for cesarean sections. Seventy-one percent of the CWRU respondents favored using spinal anesthesia for vaginal deliveries, while the nationwide use was 14 percent.

According to 80 percent of the respondents in both studies, the initial examination of the newborn infant is preliminary, and this examination usually is performed by the obstetrician.

Sixty-nine percent of the responding Cleveland hospitals and 16 percent of the ACOG-study hospitals indicated the anesthesiologist provides immediate care for the patient in distress.

Conclusion

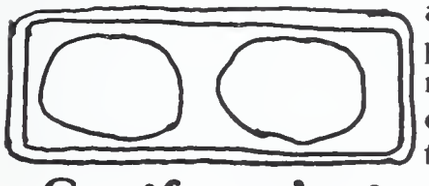
Two primary differences between the CWRU-study group and the ACOG study account for the bulk of the minor discrepancies surfacing in this survey. The first is the greater ratio of large (more than 1,000 deliveries per year) to small hospitals in Cleveland than exists nationwide. The second is the greater use of anesthesiologists in obstetrics in Cleveland than is evident throughout the nation. However, these unique characteristics serve to emphasize the importance of regular-interval surveys of the audiences involved in this particular aspect of health care.

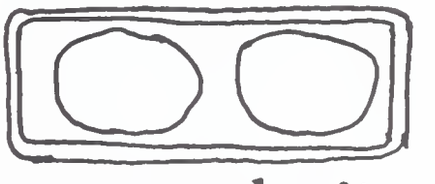
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Measles in Ohio—Update

Thomas J. Halpin, M.D., M.P.H.
James S. Marks, M.D.
John H. Ackerman, M.D., M.P.H.

There has been a major increase in measles morbidity nationwide with Ohio and neighboring states among those showing the largest percentage increases. In measles outbreaks in Ohio, the highest risk of disease was found to be in the 10- to-14-year-old children. Measles vaccine has been found to provide effective long-term immunity when initial seroconversion has occurred. Evidence for lower rates of seroconversion in infants under 13 months of age is reviewed, and recent changes in immunization recommendations are discussed.

NATIONALLY, reported measles morbidity declined from a high of about 458,000 in 1964 to a low of 22,000 in 1968 after widespread use of measles vaccine. In recent years, the number of cases has hovered in the 22,000-to-26,000 range until 1976 when major increases in morbidity were reported.[1] In 1976, there were 39,585 cases reported, 64 percent more than in 1975. This increased morbidity was led by an even larger increase in the East North Central states, of which Ohio is one. In 1976, Ohio reported 626 cases compared to 107 in 1975, an increase of 584 percent. Thus far in 1977, nationwide reporting is running twice as high as in 1976. Again Ohio and surrounding states are showing even larger increases.[2]

With this significant increase in morbidity, it becomes important for the practicing physician to keep abreast of the changing recommendations for measles vaccination and revaccination. This report will examine the epidemiology of measles with specific reference to the Ohio experience and review the recent changes in immunization recommendations put forth by the American Academy of Pediatrics and the U.S. Public Health Service (USPHS) Advisory Committee on Immunization Practices. In addition, recommendations for revaccination will be discussed.

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Submitted February 10, 1977.

Epidemiology

Particularly in urban areas, measles was a disease of the preschool child. In rural areas with less chance for contact prior to school entry, measles usually occurred in early elementary school in the 5- to-10-year-old. Recently, the major outbreaks that have occurred are in junior and senior high schools.[3] Despite this, significant morbidity still occurs in the preschool and early-grade-school child, especially in urban areas.

Measles remains among the most serious of the common childhood diseases today. The Center for Disease Control estimates that approximately one in 1,000 children who contract the disease develop encephalitis. Retardation post measles is estimated to occur in one in 3,000 cases. Pneumonia occurs in about one in 100 cases and is a major contributor to the hospitalization rate estimated at 0.6 percent of all cases. This pneumonia may be viral or secondary bacterial. Mortality occurs in one in 10,000 with the highest rates occurring in the infant and in the older adult.[4]

With national reporting estimated at 10 percent of actual cases, this would mean that Ohio had an estimated 6,260 cases in 1976. In 1975, twenty of the 88 counties reported measles cases; in 1976 this number was 27. If, however, ten or more cases are considered indicative of significant activity, only three counties reported significant activity in 1975. These counties were among the ten most populous in the state. In 1976, thirteen counties reported significant activity and only five of these were among the most populous.

Ohio experienced three large-scale outbreaks in 1976. Preble County recorded 86 cases from February through May. Defiance County reported 169 cases with peak

activity in early February but with persistent activity through March. Licking County had the largest number with 359 cases reported. This outbreak occurred in November and December. Fifty-three percent of the cases in Defiance County and 41.8 percent of those in Licking County occurred in children aged 10 to 14 years (Table 1). All ages were at risk, however, with the youngest being 4 months old and the oldest 70 years of age.

TABLE 1. Age Distribution of Measles Cases in Ohio Outbreaks

Age (Years)	Defiance County		Licking County	
	No. of Cases	%	No. of Cases	%
0 to 4	17	10	11	3
5 to 9	53	31	98	27
10 to 14	89	53	150	42
15 to 19	10	6	89	25
20+	0	0	11	3

In the Licking County outbreak in two elementary schools reporting a total of 31 cases, records were checked on all children. Twenty-four cases met clinical criteria and had adequate vaccine records. Analysis of vaccine efficacy revealed that, for all children regardless of age at vaccination, efficacy was 81.4 ± 4.5 percent. For those children vaccinated at less than 12 months of age, the efficacy was 26.9 ± 13.0 percent. Of children vaccinated at greater than 12 months of age, only 4.5 percent contracted measles. This is contrasted with children vaccinated at less than 12 months of age where 28.1 percent developed disease. Among unvaccinated children, 38.5 percent contracted disease. This points out the importance of vaccination and especially vaccination of those older than 12 months.

Vaccine

Live measles vaccine has been marketed since 1963 with the more attenuated strains available since 1965. An estimated 80,000,000 doses have been administered nationwide. There has been concern that vaccine-induced immunity may wane with time. Krugman cites data indicating that, of children immunized with further attenuated strains of vaccine 12 years earlier, 91 percent continued to have detectable levels of measles HI titers. Furthermore, in seven children whose antibody levels were undetectable, reimmunization was followed by a typical booster response rather than a primary response. He concludes that these children were still immune prior to revaccination despite undetectable antibody levels.[5]

Thus, lowered vaccine efficacy in children vaccinated prior to 12 months of age seems to be related to an initial failure to seroconvert rather than a waning of immunity established by successful vaccination. This failure to seroconvert is thought to be caused by persistence of maternal antibodies. Evidence for this failure to exhibit seropositivity shortly after vaccination has been demonstrated most recently by Yeager et al, who confirmed that children vaccinated at under 12 months of age had lower rates of detectable HI titers. More importantly, however, she found that even among those children vaccinated prior to the 13th month, 14.6 percent failed to exhibit detectable titers. For those immunized after 13 months of age, only 5.2 percent failed to have detectable titers to measles vaccine.[6] This new data led the American Academy of Pediatrics and the USPHS Advisory Committee on Immunization Practices to reevaluate and revise their recommendations. They now recommend that primary vaccination be delayed until 15 months of age rather than the previously recommended 12 months of age.[7-8]

Discussion

An immunization survey of children entering school in Ohio conducted in 1974 and 1975 found 90.5 percent of children to be immunized against measles. The variation among counties ranged from 75.6 percent to 98.8 percent.[9] However, the Licking County data shows that, while only 4.4 percent of those schools' population was unvaccinated, these unvaccinated children accounted for 20 percent of the cases of measles. Thus, even small numbers of unvaccinated children can be important in maintaining an outbreak.

The inadequately vaccinated are the other major group of susceptibles who are important to the maintenance of measles transmission. These include those who were vaccinated prior to 12 months of age, those who received the killed vaccine, and those who received live vaccine with gamma globulin which was not properly adjusted for weight.

Primary vaccination is now recommended to be given at 15 months of age in communities not experiencing significant measles morbidity. This recommendation includes the use of the combined measles/mumps/rubella vaccine. (See Table 2.) There was no recommendation to systematically revaccinate those children previously vaccinated between 12 and 15 months of age. Studies are now in progress to determine if these children have a greater susceptibility to illness during outbreaks than those vaccinated at a later age.

Ohio law mandates that a child be vaccinated against measles prior to school entry. School officials are empowered to refuse entry until proof of vaccination is demonstrated. Because of the increased measles morbidity now occurring, physicians should review the records of those older children seen during preschool examinations or other office visits to determine their need of revaccination. School officials should be encouraged to review school records to identify those children not properly immunized. Measles control can only be achieved with a concerted effort to immunize those never vaccinated and to reimmunize those whose previous vaccinations were found to be inadequate. When vaccination status is in doubt in outbreak situations, revaccination should be performed, especially since revaccination has not proved to be harmful. Suspected cases of measles should be reported promptly to local health departments to aid in initiating community measures aimed at preventing secondary measles morbidity. Only in this way can effective measles control occur.

Table 2. Summary of Vaccine Recommendations

A. Primary Vaccination
   All children with no history of vaccination and no history of disease.
   Should be done at 15 months of age in infants.
B. Revaccination
   1. All children previously vaccinated with killed measles vaccine.
   2. All children previously vaccinated prior to 12 months of age.
   3. All children previously vaccinated with live vaccine plus gamma globulin in excess of 0.02 cc per kilogram.
C. Special Situations
   1. Outbreaks and Epidemics
      (a) Infants older than 6 months and younger than 15 months old should be considered for primary early vaccination because of their higher rate of complications from disease. Will require revaccination when older than 15 months of age.
      (b) Any child without a well-documented record of past history of measles or of proper vaccination older than 12 months of age should be revaccinated. Included here are those children who might have received gamma globulin with live vaccine where the dosage is unknown.
      (c) Despite the questions raised regarding adequacy of measles immunization when given between the 12th and 13th month of age, evidence is not available to make a firm recommendation regarding revaccination of these children. However, because of recent serologic data, it may be wise to revaccinate these children if outbreaks occur in their community.
   2. Immune Serum Globulin
      May be indicated for susceptible household contacts of measles patients especially those under 1 year of age. It may prevent or modify the disease if given within six days after exposure. Recommended dose: 0.1 cc per pound of weight. Later, these children will need to be vaccinated at older than 15 months of age and at least three months after receiving immune serum globulin.

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Community Medicine

Martin D. Keller, M.D., Ph.D.

COMMUNITY MEDICINE is a composite discipline that is generally defined too narrowly or too broadly. As a matter of fact, at this time, there is no clear agreement on the delimitation of the borders and content of this field. Each member of the "confraternity" of community medicine sees it through the filter of his particular experience and professional bias. For this reason, a word about my own background appears to be in order. This will allow the reader to examine my views in their context. I am an internist by training and an epidemiologist by persuasion. In addition to my medical studies, I pursued a graduate program that led to the doctorate degree in biology. Perhaps it was the latter experience that directed my attention and interest to the complex ecology of human health and disease.

It may be apparent to anyone who examines the academic scope of community medicine that a variety of programs, clearly related to this field, are designated by different names. Each has certain implications for the program itself and for its relationship to the general university and to the professional community. For example, "public health" may imply that the major concern is with public sector activities in protecting and fostering human health. However, it soon becomes apparent that the border between the public and the private sectors in health care often are vague and, in some cases, indistinguishable. With increased public financing of health care, this ambiguity is more than likely to increase. Our own Department operates under the designation of "preventive medicine." This clearly implies concern with the variables associated with disease causation and the development of strategies to prevent the occurrence of the disease or to disclose its presence at an early stage to maximize chances of recovery or limitation of disability. Perhaps the broadest term would be "community health," implying the interaction of a variety of biologic and social variables in the complex determination of the health status of a defined population. However, in both professional and public views, community health is frequently taken as synonymous with public health, namely, health care activities supported by legislation and allocation of public funds. In some instances, mostly in other countries, the designation of "social medicine" conveys the same focus and area of interest. In this country, however, the word "social" is frequently confused with a political ideology or economic philosophy. As a consequence, we most frequently use the designation "community medicine" to make it clear to physicians and allied medical professionals that this is an area that lies within the borders of their interest.

To put it all together, the field of community medicine is concerned with all of this and:

1. It deals with people living in communities or groups having certain cultural, ethnic, occupational, attitudinal, and behavioral similarities and diversities.
2. It concerns itself with the biological, chemical, physical, and social variables that make up the complex etiologic network of human health and disease.
3. It is concerned with the delineation of the risk factors associated with the incidence of specific diseases that are amenable to control.
4. It crosses the indefinite boundaries between public and private sector activities in the delivery of health care to the population, to develop strategies to block or modify the occurrence of specific diseases.

Community medicine is a composite discipline concerned with the factors that affect the health status of defined human populations or communities. Our view of the discipline may be understood by examining the curriculum we have devised in our Department. The objectives of the curriculum are the preparation of researchers and practitioners dedicated to developing health-protection and life-support systems in all environments in which humans live and work. It can be seen readily why our Department has concerned itself with the health hazards of the work environment and with such special areas as aerospace medicine. However, the major concern is the development of strategies for disease prevention and health promotion in the more general communities. The specific disciplines involved are: (1) epidemiology; (2) biometrics; (3) the nature and function of the health care system; and (4) environmental health.

Epidemiology

Epidemiology is the discipline that deals with the study of distribution and determinants of disease in human populations. It is concerned with variations in frequency of disease over time and space and definition of the "profile" of the individual most likely to suffer

(continued on page 153)

When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg

offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

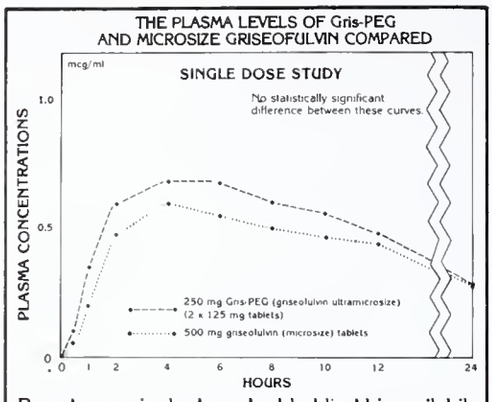
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence at this time that this confers any significant clinical difference in regard to safety or efficacy.



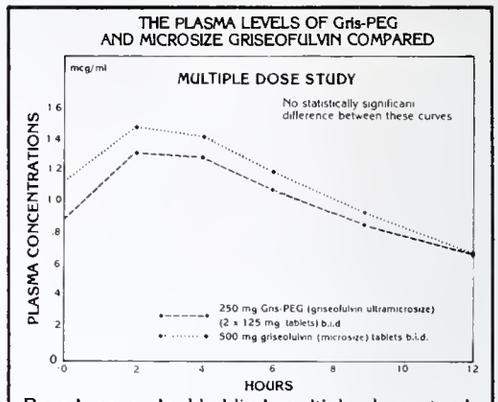
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LINCOLN, NEBRASKA

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologicelly equivelent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided deily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogrem (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YB

from a given disease. This is aimed at specification of agents and environmental factors characteristically associated with "high-risk" individuals. What sets the high-risk individual apart from the rest of the community? Is it a genetic difference, a cultural pattern, a specific exposure to a noxious agent, or a combination of several such factors? By comparing persons who have a specific disease with suitable control groups, a series of hypotheses may be generated regarding the etiology or the network of causality associated with occurrence of this disease. Strategies of intervention then may be devised to attack a vulnerable strand in the network of causality, even when specific etiology cannot be determined. There is a long and impressive history of such intervention. Historic high points include Jenner's vaccination for smallpox, Snow's control of epidemic cholera, and the control of scurvy by introduction of citrus fruit into the seaman's diet. Contemporary advances include the testing of polio vaccine, the relation of cigarette smoking to lung cancer, and the relation of blood lipids to coronary disease. Many conditions for which we have not yet identified specific etiologies can be aproached through investigation of the characteristics and environments of the ill as compared with the well. Strategies for intervention may be devised well in advance of detailed understanding of etiology and pathogenesis. Social, cultural, and demographic changes in our society are continually altering patterns of disease, both favorably and unfavorably. By studying trends in disease occurrence, the discipline of epidemiology serves to unravel the complex network sufficiently to allow purposeful action in favor of improvement of community health status.

Biometrics

The principles of biometrics are applied to the design of investigations to test hypotheses generated in epidemiologic research. The object is to arrive at estimates of community health status and its relationship to specific risk factors. Epidemiologic data are thus put together to arrive at "community diagnoses" that constitute the rationale for community health care programs. The combination of epidemiology and biometrics stands as the intelligence apparatus of community campaigns against disease. It is quite appropriate that the field-investigational arm of the National Center for Disease Control is called Epidemic Intelligence Service. Actually, the principles of epidemiology and biometrics are applicable to clinical research and to other areas of the life sciences. In our Department, the biometrics laboratory serves investigators in a great variety of the life-science disciplines. The essential difference in community medicine lies in the application of these methods to data derived from defined populations or communities, rather than from series of patients or from laboratory experiments.

Dr. Keller, Columbus, Professor of Preventive Medicine, The Ohio State University College of Medicine.
Submitted December 15, 1976.

Nature and Function of Health Care System

Since the realm of epidemiology is the community or population group, application of the findings of epidemiologic research must be compatible with the nature of the community and its organization of health care delivery. Consequently, one of the key areas in community medicine involves detailed study of the nature and function of the health care system. It is necessary to be aware of the ways in which people seek and obtain health care and how such care is provided. Combining such information with the results of epidemiologic research, the task then is to translate the results of research into specification of health care needs and development of intervention strategies adapted to the nature of a given community. The same disciplines are applicable to evaluation of the impact of changes in health care delivery. Thus, community medicine becomes a basic approach to health planning and program evaluation.

Environmental Health

In a sense, all human disease can be related to environmental agents. Given certain genetic predispositions, there still remains a necessary interaction between the individual and the environment to develop an expression of disease. A major concern of community medicine is the identification of specific agents in the environment that are associated with identifiable disease in the community. Traditionally, attention has focused on biologic agents and, specifically, on the control of communicable diseases. However, in technologically advanced societies, the effects of microbiologic agents frequently are over-shadowed by "microchemical" agents of disease. In an increasingly complex chemical environment, new substances are constantly introduced and unusual concentrations of already-existing substances are encountered. For the most part, we know little about the way in which such substances are distributed in nature, the amounts that enter and are retained by human tissues, the way in which they are metabolized, and how they affect human health. This is a major concern of contemporary society, as evidenced by the growth of environmental protection programs and the complex of regulatory and investigatory agencies dealing with such problems. Investigation of the distribution of such environmental agents and their impact on the health of human populations lie within the general scope of community medicine.

Community Diagnosis

As noted herein, in any proposed community health program, the disciplines of community medicine are concerned at the outset with community diagnosis. This requires designation of the population to be served and estimation of the incidence and prevalence of a defined disease or health status measure. However, morbidity rates are difficult to come by. Even among the reportable communicable diseases, the data are frequently inaccurate. In other diseases, morbidity data generally are unavailable. It becomes the task of the community medi-

cine specialist to use all available sources, including hospitalization data, insurance data, and any other health care records to make reasonable estimates. Where this is not adequate — and for the most part it is not — it may be necessary to carry out local surveys to obtain usable information. Mortality data are of limited use except in very specific diseases in which there is likely to be adequate ante-mortem diagnosis. At any rate, the magnitude of a selected health problem in the community must be specified in relation to overall community health needs, so that appropirate priorities can be assigned. It is of interest to note that accidents, cardiovascular diseases, respiratory disease including lung cancer, and suicide deprive our society of the greatest number of potentially productive years. Yet, the role of medical care in salvaging these lost years is quite minimal. It is clear that medical care must be combined with a variety of social and environmental interventions in order to have significant impact on these major problems.

Preventive Programs

Since the resources of our society are limited, it is important to direct health efforts to individuals who are most likely to benefit from a given program. For example, a coronary prevention program may be applied most appropriately to a segment of the population that has been screened and designated as having high risk. In our own studies, we have found that approximately 7 percent of working males between the ages of 40 and 59 years have serum cholesterol and blood pressure levels that imply high risk of coronary disease. Therefore, it would be logical to develop a screening program for such identification as part of a program aimed at the primary prevention of coronary disease. Perhaps the age group should be younger for more effective primary prevention.

Another approach would be to work through the regular sources of health care to insure that appropriate screening tests are accurately applied as part of general health care. Unfortunately, we found that over half of the 14,000 men who were screened had little or no regular contact with a physician. In fact, a substantial number named their wives' obstetricians as the only physicians they knew.

Whatever mechanism may be adopted to identify individuals in need of specific health care, the specialist in community medicine seeks to determine the most effective ways of delivering such care. For example, the person with high risk of coronary heart disease may require management of hypertension, nutritional advice for control of weight and serum cholesterol levels, guidance in a graded exercise program, help in giving up cigarette smoking, and a variety of other services. Not all of these may be available in the physician's office. Presenting the patient with some literature and brief advice usually does not accomplish very much. We were able to demonstrate, in our coronary prevention study, that the coordinated effort of medical and paramedical personnel can effectively motivate and guide high-risk patients to alter their behavior and significantly reduce defined risk factors. Studies are now in progress in several parts of the country that will yield information regarding the overall impact of such preventive measures on coronary morbidity and mortality.

Screening Tests

The concerns of community medicine do not end with primary prevention. One of the most active areas of current research involves the detection of inapparent disease through combinations of screening tests. Some pessimism has been expressed regarding the potential value of this approach. However, this is a reflection of the misapplication of the method. Large batteries of tests indiscriminately applied to groups of individuals in community surveys and in a variety of health care settings are not likely to be of much use. There is little justification for a "shotgun" approach to disease detection, anymore than there is justification for a "shotgun" approach to the treatment of disease. Age, sex, family history, personal medical history, occupation, and other variables serve to indicate specific risks. These serve as guides to the individualization of screening for inapparent disease. Except for research purposes, there is little justification for applying any test whose results are not likely to lead to intervention in the preservation of the patient's health. In our view, community medicine should concern iself with epidemiologic definition of risk as it is related to the types of variables mentioned herein. Such information will serve the provider of health care in selecting tests that are appropriate for given patients and in scheduling them at rational intervals.

While it is best to have screening tests carried out in the context of regular medical care, community health authorities also must be concerned with individuals who do not have regular sources of health care and, therefore, would be missed. The estimation of the numbers and characteristics of such individuals in the community is a task for community medicine as well. We frequently hear of the over-utilization of medical services. However, it is a truism that any system that studies only the individuals who enter will be conscious only of over-utilization or "false-positives." Those who under-utilize the system are not known to the providers of health care. They may be detected only at the very late stages of an illness that might have been prevented or modified. These are the "false-negatives" that often are overlooked in health-care-utilization studies.

Community Medicine and Medical Care

To complete the picture, it is important to examine a major area in which community medicine and clinical medical care overlap. This involves persons with overt illness seeking medical care. The problem here is the promptness and effectiveness of the response of the community health care system. One of the areas to which

we have devoted a considerable amount of study is that of emergency medical care. In our definition, this exemplifies the response of the health care system to the "unexpected events." Anyone who has studied the patients treated by ambulance and hospital emergency department personnel will agree that a large proportion would not be considered very urgent. However, in this aspect of the health care system, the need for care is uniquely defined by the patient or by someone close to him. Providers of emergency medical care usually cannot define the urgency until after the patient is seen. It is clear that, no matter what type of health care system is developed, there is bound to be some demand for care outside the scheduled portion of the system. Community medicine is concerned with defining the magnitude of this demand and seeking ways, through the effective application of health care, to limit such episodic care to a reasonable level and to integrate it effectively with more satisfactory, continuing health care.

In relation to clinical medical care, epidemiology is concerned with population studies to define and test the reliability of diagnosis and the effects of therapeutic intervention on clinical outcomes. Beyond the collection of series of cases, clinical epidemiology is concerned with the representativeness of such samples for generalization. Consideration is given to such intervening variables as patient compliance with medical advice, social and cultural variables that interfere with compliance, and the adverse effects of treatment that might be missed. Through case-control and cohort studies, the natural history of a disease is explored in order to ascertain differences in outcome following therapeutic intervention from outcome without treatment.

Career Development

The potential impact of the program in community medicine may be assessed in part through the career development of the graduates. Since 1954, the Department of Preventive Medicine at the Ohio State University College of Medicine has conducted a graduate program leading to the completion of specialty requirements and graduate degrees in the fields of occupational medicine and aerospace medicine. In 1970, we added a residency in general preventive medicine. Graduates of these programs are now engaged in key positions in academic institutions, in the aerospace industry, in a variety of occupational health programs, in federal and state health agencies, and in international health programs.

In 1969, the Division of Community Medicine embarked on a new enterprise. It was apparent then that there was a national need for well-trained academicians and practitioners in the disciplines that comprise community medicine. This specialty offers a fruitful field for physicians as well as for students from a variety of other academic backgrounds. Consequently, we extended our offering not only to physicians but to qualified students of the biological, physical, and social sciences. Our nonmedical graduates have since taken posts in federal health agencies, in a variety of state and regional health programs, and in international health programs. In a relatively short period of time, it has been possible for us to disseminate, through our students, an approach to the health care delivery system that, at least in part, is peculiarly our own. As a Department within the College of Medicine, we are closely related to problems of medical care and are able to combine the larger view of community medicine with a sense of the particular needs of physician-patient interaction. This, perhaps, has been one of the reasons for the success of many of our students in attaining leadership roles in their areas of endeavor.

For our medical students, we have developed a rotation in community medicine built on assignments in a variety of community health programs away from the College of Medicine. Students work with practitioners and with agencies concerned with many aspects of community health care delivery. We are now in the process of assessing the impact of this experience on the career choices and attitudes of our medical graduates. The first group of medical students to enter the program are now in their fourth year after graduation. We can begin to assess some of the effects of their experiences in community medicine on the directions of their careers and their attitudes regarding their roles in the overall health care system. This will guide our future curriculum development.

Research

Our research endeavors also may offer the reader some insight into the nature of community medicine. It is our view that most of the key problems of human health are bound up in a complex network of causality that can be approached best by a coalition between the health care establishment and a variety of other social subsystems. We are keenly aware of the fact that major changes in health status of the community result at least as much from changes in life styles and environment as they do from the application of medical science. For example, our society faces complex economic trade-offs between some aspects of industrial and technologic growth and the control of environmental agents that endanger human health. The discipline of community medicine can serve to point out the consequences of certain interactions between environmental agents and human populations, and to indicate possibilities of effective intervention. This offers our society essential information for decision making.

Research in our department has ranged across such diverse areas as infectious disease control, prevention of coronary heart disease, occupational health and safety, life support systems in special environments, environmental agents of human disease, emergency medical care, and a variety of other seemingly diverse subjects. However, they are bound together by the application of the disciplines that comprise community medicine. The common thread is the investigation of the factors associated with the causation of illness and the strategies that may be effective in maintaining the health of our populations.

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Maternal Health in Ohio

A Six-Year Perinatal Study

By the OSMA Committee on Maternal and Neonatal Health

SINCE ITS INCEPTION in 1956,[1] this Committee has published over 140 articles containing case reports and data from the Ohio Maternal Mortality Study. All of this material was carefully tailored to provide continuing medical education for Ohio physicians and members of the allied health professions who dealt with pregnant patients.

Previously, the Committee has reported only *maternal deaths* and their prevention. However, since the scope of activities promoted by the Committee was enlarged last year to encompass various perinatal problems, members are proud to present results of a regional project now in operation for over six years.

Background

During the 50th meeting of the Committee on Maternal Health, January 18-19, 1969, J. Hutchison Williams, M.D., reviewed the "AMA Statement on Perinatal Mortality." Thereafter, a letter received by the President of the Ohio State Medical Association (OSMA) from the American Medical Association (AMA)[2] was carefully read to Members of the Committee. This significant document was seeking information that could be used in developing a program to reduce *infant mortality* in the United States.

As a project, the data was requested specifically on Summit County, Ohio (Akron). Charles V. Bowen, Jr., M.D., Committee Member, was duly appointed by the Chairman to explore and develop such a project in Summit County.

Development

Dr. Bowen reported on his efforts and progress at the 52nd meeting of the Committee, January 17-18, 1970. Support and assistance had been assured by Dr. Martha D. Nelson, Commissioner of Health, Summit County, and officials of various hospitals in Akron. From time to time thereafter, Dr. Bowen presented successive reports on the collection of data to the Committee.

Several years ago (1973 and 1975) Dr. Nelson and Dr. John Morley, Akron Health Commissioners, succeeded in establishing two *prenatal* clinics in the "gray areas"* of Akron. The aim — "finding expectant mothers early."

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal and Neonatal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the studies by the Committee, based on anonymous data submitted, are presented from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

*Gray areas are inner city and city areas with predominantly indigent families.

High-risk obstetric patients were discovered promptly and received intensive care throughout their gestations. Clinics were staffed by public health nurses and maternity nurses. Medical direction and supervision of the clinics was provided by residents in obstetrics and gynecology from Akron City and Akron General Hospitals. Nutritionists and social workers augmented the staff. All maternal health services were maintained according to standards of the American College of Obstetricians and Gynecologists (ACOG); the Nurse Association of the ACOG, and the Ohio Department of Health. Officials indicate that the accomplishments exceeded the projected expectations; only 45 percent of the mothers had complications, in contrast to the 60-percent figure that had been forecast.

Results

Brief statistics for these clinics during a one-year period are shown in Table 1. In a 12-month period, there were 343 patient visits.[3] Of 97 new patients reported during this period, 62 were in the age group of 14 to 19 years. The majority of patients were referred to the clinics by patients' relatives or friends, from planned parenthood clinics, or from the health department.

Table 1. Statistical Report—Akron Health Department Prenatal Clinics, 1975-1976

Joy Park Clinic	4/75-1/76	Total Patients	108
Central Clinic	1/75-1/76	Total Patients	155

	Married	Single
Central Clinic	66	89
Joy Park	35	73

	Black	White	Other
Central Clinic	64	89	2
Joy Park	48	60	

Age	Central	Joy Park
Under 15	3	2
15-19	101	65
20-24	23	24
25-29	21	11
30-34	4	2
35-39	2	4
40-44	1	

Total Deliveries
104 @ Akron City Hospital
25 @ Akron General Hospital

Total Fetal Deaths - 4
1 - Aborted twins @ 4 months
1 - Aborted @ 6 months
1 - Abruptio placenta (Joy Park Clinic)

Infant Deaths - 2
1 - Premature with congenital heart disease
1 - Full-term infant with congenital disease (heart)

Source of Referrals:

	Joy Park	Central Clinic
Planned Parenthood	17	29
Relative, self, or friend	25	25
Health Department	23	34
PMD	7	25
Hospital	8	10
S.C.W.	14	6
U.F.	6	12
Birthright	4	5
School	4	9
	108	155

Five hospitals in the area provide excellent maternity services. (See Table 2.) These are classified as Class II installations. Newborn infants needing specialized care are transferred to Children's Hospital (Class III installation) which is fully equipped and has the facilities to render expert care to the high-risk infant. Excellent, prompt transportation of these newborns is furnished in a fully equipped ambulance staffed by a physician from Children's Hospital; the newborn child is picked up at one of the five hospitals and transported immediately to Children's Hospital for intensive care. All of the five hospitals have fetal monitors and the usual equipment, but they do not have the superior facilities to provide specialized, intensive care for the newborn. Officials advise that this system has operated with great success.

For the most part, the overall perinatal mortality rate has diminished appreciably during the six years reported (from 22.2 to 12.97 perinatal deaths per 1,000 live births, as shown in Table 2). Proportionately, this comparative rate exceeds changes in the number of live births for the same period (from 10,816 to 7,889).

Conclusions

1. There was a distinct *decline* in the number of perinatal deaths in Summit County, Ohio during the six-year study period from 1970 to 1976. This is particularly impressive considering the reduction in the number of stillbirths and neonatal deaths (Table 2).

2. The establishment and maintenance of neighborhood prenatal clinics is believed to have contributed immeasurably to public education and improved maternity care. In turn, both of these factors influenced the reduction in perinatal deaths. Additional clinics will be established in the near future.

3. The operation of a highly efficient transportation service for "high-risk" newborn infants provided prompt access to superior facilities (at Children's Hospital) for the "newborn in trouble."

4. Although not included in these figures, the improvement of care and facilities (fetal monitors and other equipment) has made a major contribution to the decline in neonatal deaths. The cesarean section rate in the Akron area recently has risen to 15 percent, and more recently to 18 percent of the deliveries.

Summary

1. A six-year study of perinatal mortality in Summit County, Ohio is presented.

2. Factors and features in the development and operation of the various services are discussed.

3. Results and statistics gleaned from the study indicate a conclusive decline in the perinatal mortality rate

Table 2. Live Births and Perinatal Mortality Statistics, Summit County, Ohio, Six Years, 1970-1975

Hospital	Total No. Live Births	Total No. Stillbirths	Total No. Neonatal Deaths	Perinatal Mortality Rate per 1,000 Live Births 1975	1974	1973	1972	1971	1970
Barberton Citizens	1495	14	12	17.04	21.90	13.13	13.64	26.36	14.38
Green Cross	308	1	1	5.74	16.89	17.72	22.49	25.21	35.59
Akron General	1775	9	21	16.11	18.05	22.51	20.62	23.08	20.23
Akron City	2725	15	17	12.16	11.95	15.16	23.84	26.18	24.18
St. Thomas	1586	10	13	13.80	13.42	14.13	19.91	24.41	16.65
T *1975*	7889	49	64						
O *1974*	7848	77	54						
T *1973*	7919	55	78						
A *1972*	8226	87	84						
L *1971*	9549	113	103						
S *1970*	10816	120	88						

Perinatal Mortality Rate for Summit Co. - 1975....12.97
" " " " " " 1974.....16.44
" " " " " " 1973.....16.53
" " " " " " 1972.....20.10
" " " " " " 1971.....25.05
" " " " " " 1970.....22.20

Increase in Births from 1974 to 1975 - 41 or 1.10%
Decrease in Births from 1973 to 1974 - 71 or 1.01%
Decrease in Births from 1972 to 1973 - 307 or 3.73%
Decrease in Births from 1971 to 1972 - 1323 or 13.85%
Decrease in Births from 1970 to 1971 - 1267 or 11.71%

during the six years covered.

4. Results and conclusions provide predominant points in evaluating the simple-but-effective methodology employed.

Recommendation

The Committee strongly recommends that other metropolitan areas in Ohio explore and develop plans to promote a project similar to the Akron survey.

References

1. OSMA Committee on Maternal Health: Maternal deaths due to hemorrhage. *Ohio State Med J* 52:951-952, 1956.
2. Personal communication, Wayne G. Menke, M.D., Secy, Committee on Maternal & Child Welfare, AMA, to President of OSMA.
3. Special communication, Martha D. Nelson, M.D., concerning prenatal services in Summit County, Ohio from Oct. 1, 1974 to Sept. 30, 1975.



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1977 OSMA Annual Meeting Courses

Columbus, May 14-18, 1977

Saturday Programs

ETHICAL DILEMMA OF CRISIS MEDICINE

Fee: None
Date: Saturday, May 14
Time: 2-5 PM
Sponsor: OSMA
Course Director: *Donald J. Vincent, M.D.,* Chairman, OSMA Section of Directors of Medical Education; Chairman, OSMA Committee on Medicine and Religion; and Director of Medical Education, Riverside Methodist Hospital, Columbus

NEGOTIATING

CME Hours: 14 Category I
Fee: $125 OSMA members; $175 Non-members
Date: Saturday, May 14
Sunday, May 15
Time: Saturday: All day
Sunday: 9 AM-12 NOON
Enrollment: Limited to 60
Sponsor: OSMA
Course Director: *Charles L. Hughes, Ph.D.,* Director of Personnel, Component Groups, Texas Instruments Inc.; and *J. Paige Clousson, Esq.,* Director, AMA Department of Negotiations, in cooperation with the OSMA.

PUBLIC SPEAKING

CME Hours: 11 Category I
Fee: $130 OSMA members; $145 Non-members
Date: Saturday, May 14
Sunday, May 15
Time: Saturday: 9 AM-5 PM
Sunday 9 AM-12 Noon
Enrollment: Limited to 20
Sponsor: OSMA
Course Director: *Mortimer T. Enright,* Director, AMA Speakers and Leadership Programs, in cooperation with the OSMA.

Course Synopsis: This course is planned to identify and enhance the public communication skills of participants. Message preparation, speech delivery, and the art of fielding questions will be covered in theory and drills. Personal coaching and evaluation through videotape playbacks are stressed. The faculty will emphasize those skills necessary for physicians who deliver scientific papers; speak before lay audiences on either health information or socioeconomic topics; and appear as guest experts or spokespersons on radio, television, or at press conferences.

Saturday
9 AM Seminar orientation
9:30 AM Speech preparation and delivery clinic— A combination of short lectures, drills, and videotape models to get participants familiar with advanced theory in these areas.
12 NOON Lunch
1:15 PM Create speeches in small sections
1:45 PM Rehearse speeches
2:30 PM Footwork clinic— Discussion and drills on fielding questions after speeches before live audiences while on interview shows or at press conferences. Participants' speeches videotaped in TV studio.
3:30 PM Evaluation clinic— An individual critique of each participant on organization, delivery, and fielding.

Sunday
9 AM Individual coaching

Specialty Section Programs

ALLERGY AND IMMUNOLOGY

Title: Wheezing at Work
CME Hours: 4 Category I
Date: Wednesday, May 18
Time: 8:30 AM-12:30 PM
Sponsor: OSMA Section on Allergy and Immunology, Ohio Society of Allergy and Immunology, Western Ohio Medical Association, and Tri-State Medical Association.
Course Director: *I. Leonard Bernstein, M.D.,* Clinical Professor of Medicine; Director, Allergy Research Laboratory, Allergy Clinic, and Allergy Training Program, University of Cincinnati College of Medicine

8:30 AM **The General Scope of Industrial Asthma**— I. Leonard Bernstein, M.D., Division of Immunology, University of Cincinnati Medical Center.
9 AM **Asthmatic Responses After Exposure to Industrial Chemicals**— Kenneth P. Mathews, M.D., Professor of Internal Medicine and Head, Division of Allergy and Clinical Immunology, University of Michigan Medical School, Ann Arbor

(continued on page 162)

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WHEN A HEARING AID WILL HELP

Annual Meeting Courses *(continued)*

Allergy and Immunology Continued

9:40 AM **Asthma in Workers Exposed to Grain Dusts** — Kam S. Tse, M.D., Director, Allergy and Clinical Immunology, University of Manitoba Health Sciences Center, Winnipeg, Manitoba, Canada

10:30 AM Break

11 AM **Meatwrapper's Syndrome: Clinical and Laboratory Observations**— Emil J. Bardana, Jr., M.D., Associate Professor of Medicine, Division of Immunology and Asthma, University of Oregon Medical School, Portland

11:40 AM **Panel Discussion**— I. Leonard Bernstein, M.D., moderator; Emil J. Bardana, Jr., M.D.; Kenneth Mathews, M.D.; and Kam S. Tse, M.D.

ANESTHESIOLOGY

CME Hours: 3 Category I
Date: Wednesday, May 18
Time: 1:30-4:30 PM
Sponsor: OSMA Section on Anesthesiology and the Ohio Society of Anesthesiologists, Inc.
Course Director: *Jack G. G. Hendershot, M.D.*

1:30 PM **Ventilation, Perfusion, Diffusion— The Fundamentals of Respiratory Therapy**— Jack G. G. Hendershot, M.D., Director, Dept. of Respiratory Therapy and Chairman, Department of Anesthesiology, Lancaster-Fairfield Hospital

2:05 PM **Pre- and Post-Operative Management of Pulmonary Problems**— Joseph Tomashefski, M.D.

2:40 PM Break

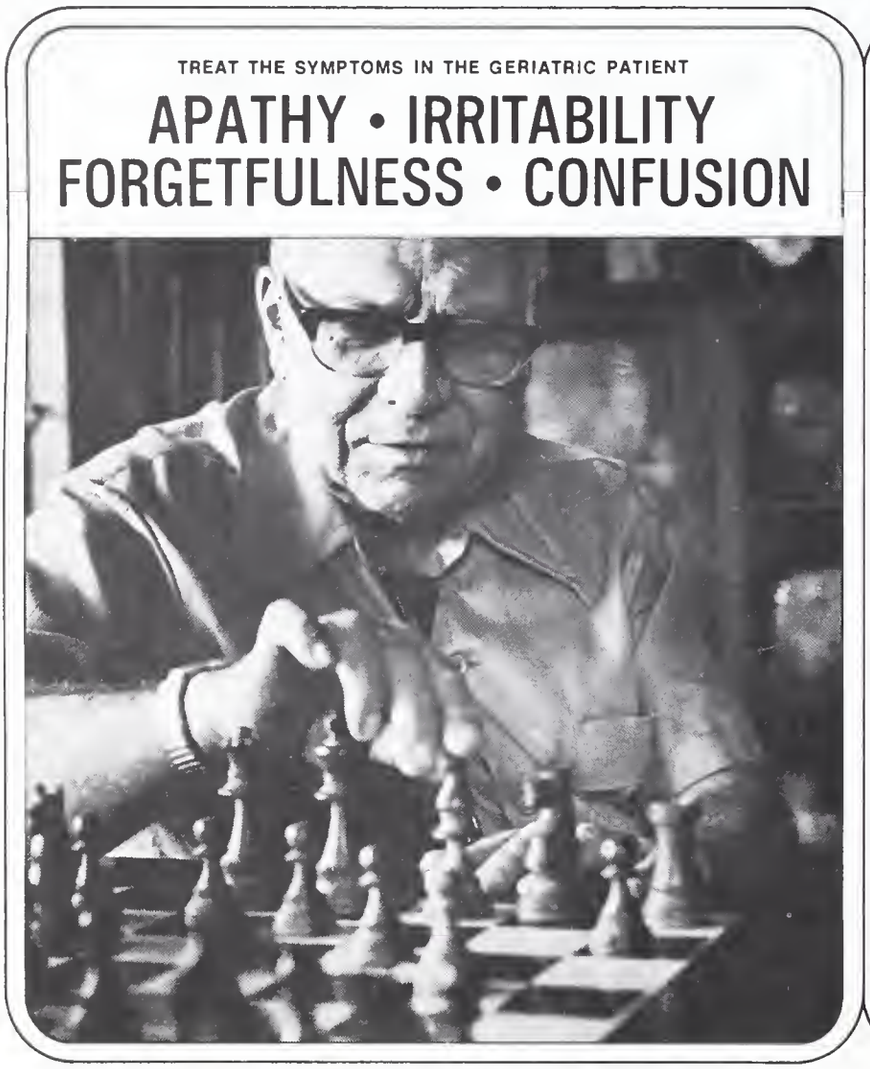
2:55 PM **Mechanical Ventilation**— Harold R. Stevens, M.D., Director, Respiratory Therapy and Director, Intensive Care Unit, Toledo Hospital

3:30 PM **A "Hands-On" Approach to Minimize Respiratory Complications**— Lawrence C. Fergus, B.S., A.R.R.T., Technical/Administrative Director, Respiratory Therapy Department, Cleveland Clinic Foundation

4:05 PM Panel Discussion— Jack G. G. Hendershot, M.D., moderator; Lawrence C. Fergus, B.S., A.R.R.T.; Harold R. Stevens, M.D.; and Joseph Tomashefski, M.D.

CHEST PHYSICIANS

Title: Symposium on Coronary Heart Disease
CME Hours: 4 Category I
Date: Tuesday, May 17
Time: 9 AM-4:45 PM



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Sponsor: Ohio Chapter, American College of Chest Physicians

Course Directors: *Raynald Lane, M.D.,* Morning Session— Director, Medical Education, St. Elizabeth Medical Center, and Associate Clinical Professor of Medicine, Wright State University School of Medicine

Stuart M. Denmark, M.D., Afternoon Session— Thoracic and Cardiovascular Surgeon, Good Samaritan Hospital and St. Elizabeth Medical Center, Dayton; Associate Clinical Professor of Surgery, Wright State University School of Medicine

9 AM **Risk Factors and Coronary Heart Disease**— James Warren, M.D., Professor and Chairman, Department of Medicine, Ohio State University College of Medicine

9:30 AM **Evaluation of Patients with Chest Pain**— Enayatollah Tabesh, M.D., Cardiologist

10 AM Break

10:30 AM **Coronary Arteriogram in Patient with Coronary Heart Disease**— Mehdi Razavi, M.D., Cardiologist and Staff Member, Department of Cardiology, Cleveland Clinic Foundation

11 AM **Prognosis After Acute Myocardial Infarction**— Sylvan L. Weinberg, M.D., Clinical Professor of Medicine and Co-Director of Cardiology, Wright State University School of Medicine, Dayton

11:30 AM Lunch

1:30 PM **Myocardial Revascularization, Concepts of Total Revascularization, Role of IABP in Surgery**— Siavosh Bozorgi, M.D., Thoracic and Cardiovascular Surgeon, Good Samaritan Hospital and St. Elizabeth Medical Center, Dayton

2 PM **Conservative Versus Aggressive Approach to Coronary Heart Disease**— James Warren, M.D., and Sylvan L. Weinberg, M.D.

2:45 PM **Impending MI and Intermediate Syndrome, Longterm Results**— Mehdi Razavi, M.D.

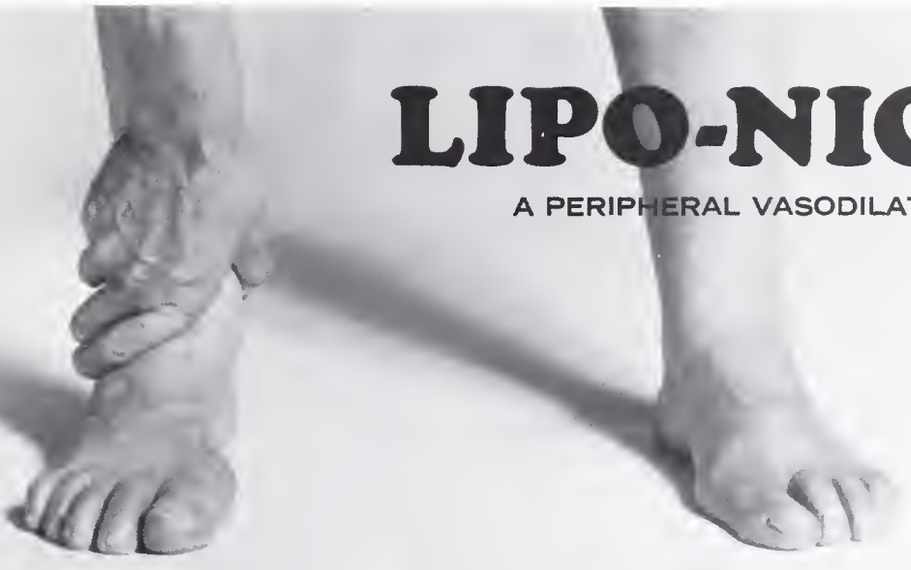
3:15 PM Break

3:45 PM **Surgical Techniques in Myocardial Revascularization**— Siavosh Bozorgi, M.D.

4:15 PM Panel Discussion— Sylvan L. Weinberg, M.D., moderator; Siavosh Bozorgi, M.D.; Chin Woo Imm, M.D.; Raynald Lane, M.D.,; Mehdi Razavi, M.D.; E. Tabesh, M.D.; and James Warren, M.D.

(continued on page 164)

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Annual Meeting Courses *(continued)*

COLON AND RECTAL SURGERY

CME Hours: 3 Category I
Date: Wednesday, May 18
Time: 1:30-4:30 PM
Sponsor: OSMA Section on Colon and Rectal Surgery, and the Ohio Valley Society of Colon and Rectal Surgery.
Course Director: *Carlos O. Andarsio, M.D.,* Chairman, OSMA Section on Colon and Rectal Surgery, Springfield

1:30 PM **Diagnosis and Treatment of Endamoeba Histolytica**— Fidel Ruiz-Moreno, M.D., Mexico City, Mexico, Professor of Colon and Rectal Surgery, University of Mexico

Surgical Management of Crohn's Disease — Victor W. Fazio, M.D.; Head of Colon and Rectal Surgery, The Cleveland Clinic, Cleveland

Ischemic Colitis— Patrick F. Hagihara, M.D., Assistant Professor of Surgery, University of Kentucky College of Medicine

DERMATOLOGY

Title: Dermatology for the Non-Dermatologist
Fee: $75
CME Hours: 6 Category I
Date: Tuesday, May 17
Time: 8:30 AM-12:00 NOON
1:30-4:30 PM
Sponsor: OSMA Section on Dermatology and the Central Ohio Dermatological Society in cooperation with the American Academy of Dermatology.
Course Director: *Wilma F. Bergfeld, M.D.,* Head, Section on Dermatolopathology, Cleveland Clinic Foundation. Other faculty: Philip Bailin, M.D., Cleveland; William Dorner, Jr., M.D., Akron; and Jerome Litt, M.D., Cleveland

GENERAL PRACTICE SPORTS MEDICINE

Title: Wide, Wide World of Sports Medicine
CME Hours: 4 Category I
Date: Tuesday, May 17
Time: 1:30-5:30 PM
Sponsor: OSMA Section on General Practice, OSMA Section on Sports Medicine, and the Joint Advisory Committee on Sports Medicine of the OSMA and the Ohio High School Athletic Association
Course Director: *James C. Good, M.D.,* Secretary, OSMA Section on Sports Medicine

11:30 AM Lunch— Members of Joint Advisory Committee on Sports Medicine.

1:30 PM Coach "Woody" Hayes, The Ohio State University

2 PM **The View from the Sidelines or Fun at Games**— H. Royer Collins, M.D., Cleveland

2:45 PM **A Younger Physician Looks at Sports Medicine**— Joseph A. Butts, M.D., Medical Staff for the Ohio State University Department of Athletics

3 PM Break

3:30 PM **Injuries From Running, Throwing, Lifting, and Falling**— Spencer Turner, M.D., Director, the Ohio State University Health Service

4 PM Panel Discussion

INTERNAL MEDICINE

Title: New Concepts in Cardiology
CME Hours: 3 Category I
Date: Tuesday, May 17
Time: 9 AM-12 NOON
Sponsor: A.C.A., Ohio Society of Internal Medicine and OSMA Section on Internal Medicine
Course Director: *Richard P. Lewis, M.D.,* Professor of Medicine and Director of the Division of Cardiology, The Ohio State University College of Medicine; and Governor for Ohio, The American College of Physicians

9. AM **Mitral Valve Prolapse Syndrome— A Perspective**— Charles F. Wooley, M.D., Professor of Medicine, Division of Cardiology, Ohio State University College of Medicine

9:15 AM **Clinical Diagnosis of Mitral Prolapse**— Mary Beth Fontana, M.D., Associate Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine

9:30 AM **Echocardiography**— Phillip K. Fulkerson, M.D., Assistant Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine

9:50 AM Questions

10 AM **New Concepts in Exercise Testing**— John L. Robinson, M.D., Associate Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine

10:15 AM **Nuclear Cardiology**— Albert J. Kolibash, M.D.

10:35 AM **Indications for Coronary Angiography**— Charles A. Bush, M.D., Assistant Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine

10:50 AM Questions

11 AM **Holter Monitoring for Diagnosis of Dysrhythmias**— Harisios Boudoulas, M.D., Asst. Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine

(continued on page 166)

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Annual Meeting Courses *(continued)*

Internal Medicine Continued

11:20 AM **Electrophysiologic Stress Testing**— Stephen F. Schaal, M.D., Associate Professor of Medicine, Division of Cardiology, Ohio State University College of Medicine

11:35 AM **The Bradycardia-Tachycardia Syndrome**— Carl V. Leier, M.D., Assistant Professor of Medicine and Pharmacology, Division of Cardiology, Ohio State University College of Medicine

11:50 AM Questions

NEUROLOGY

Title: Clinical and Experimental Approach to Brain Tumor: Pathogensis and Treatment.
CME Hours: 2 Category I
Date: Monday, May 16
Time: 1:30 PM
Sponsor: OSMA Section on Neurology
Course Director: *William E. Hunt, M.D.,* Professor and Chairman, Division of Neurosurgery, The Ohio State University College of Medicine

1:30 PM **Viral-Induced Brain Tumors: Experimental Methodology and Immunology and Morphology** — Darell Bigner, M.D., Ph.D., Associate Professor of Pathology, Duke University Medical School, Durham, North Carolina; and Nicholas Vick, M.D., Associate Professor of Neurology, Northwestern University Medical School, Chicago

Current Modes of Treatment and Possible Methods of Therapeutic Enhancement— Norman Allen, M.D., Columbus

NEUROSURGERY

CME Hours: 4 Category I
Date: Tuesday, May 17
Time: 9 AM-4 PM
Location: 9-11:45 AM Upham Hall Auditorium, Ohio State University; 1-4 PM Veterans Memorial
Sponsor: OSMA Section on Neurosurgery and the Ohio State Neurosurgical Society
Course Director: *William E. Hegarty, M.D.,* President, Ohio State Neurosurgical Society, Lakewood

9 AM **The Results of Early Operation Following Subarachnoid Hemorrhage**— Donald Oxenhandler, M.D.

9:30 AM **Observations on the Natural History of Vasopasm**— Carole A. Miller, M.D.

10:10 AM Coffee Break

10:30 AM **A Systematic Approach to Injuries of the Vertebral Column**— William E. Hunt, M.D., President-Elect, Ohio State Neurosurgical Society, Columbus

11 AM Panel Discussion: **Some Laboratory Correlations in Acute Spinal Cord Injury**— W. George Bingham, Jr., M.D.; Joseph H. Goodman, M.D.; and David Yashon, M.D., Professor of Neurosurgery, Ohio State University, Columbus

11:45 AM Lunch

1 PM Panel Discussion: **Pediatric Neurosurgery**— Edward Kosnik, M.D.; Robert McLaurin, M.D.; Frank Nulsen, M.D.; Martin Sayers, M.D. and Robert White, M.D.

2:15 PM Coffee Break

2:30 PM **The Surgery of Meningiomas**— Collin S. MacCarty, M.D., Professor of Neurosurgery, Associate Director for Graduate Education, Division of Education, Mayo Foundation, Rochester, Minn.

4 PM Business Meeting, The Ohio State Neurosurgical Society

OPHTHALMOLOGY

CME Hours: 2 Category I
Date: Tuesday, May 17
Time: 2-4:30 PM
Sponsor: OSMA Section on Ophthalmology
Ohio Ophthalmological Society
Course Director: *Abbot Spaulding, M.D.*

2 PM **Ultrasonography of Orbital Tumors**— John D. Bullock, M.D., Dayton

2:20 PM Discussion

2:30 PM **Armageddon Ophthalmologicum**— Whitney G. Sampson, M.D., Houston, Texas

4 PM Discussion

OTOLARYNGOLOGY

Date: Monday, May 16
Tuesday, May 17
Time: Monday: 1:30-4:15 PM
Tuesday: 9 AM-4:15 PM
Sponsor: OSMA Section on Otolaryngology and the Ohio Society of Otolaryngology
Course Directors: Monday: *John W. Ray, M.D.,* President, Ohio Society of Otolaryngology; Tuesday morning: *Daniel M. Lavigna, Jr., M.D.,* Secretary, Ohio Society of Otolaryngology; Tuesday afternoon: *John W. Ray, M.D.*
Note: Monday's program is designed for the family physician, internist, pediatrician, and other interested non-otolaryngologists.

Monday

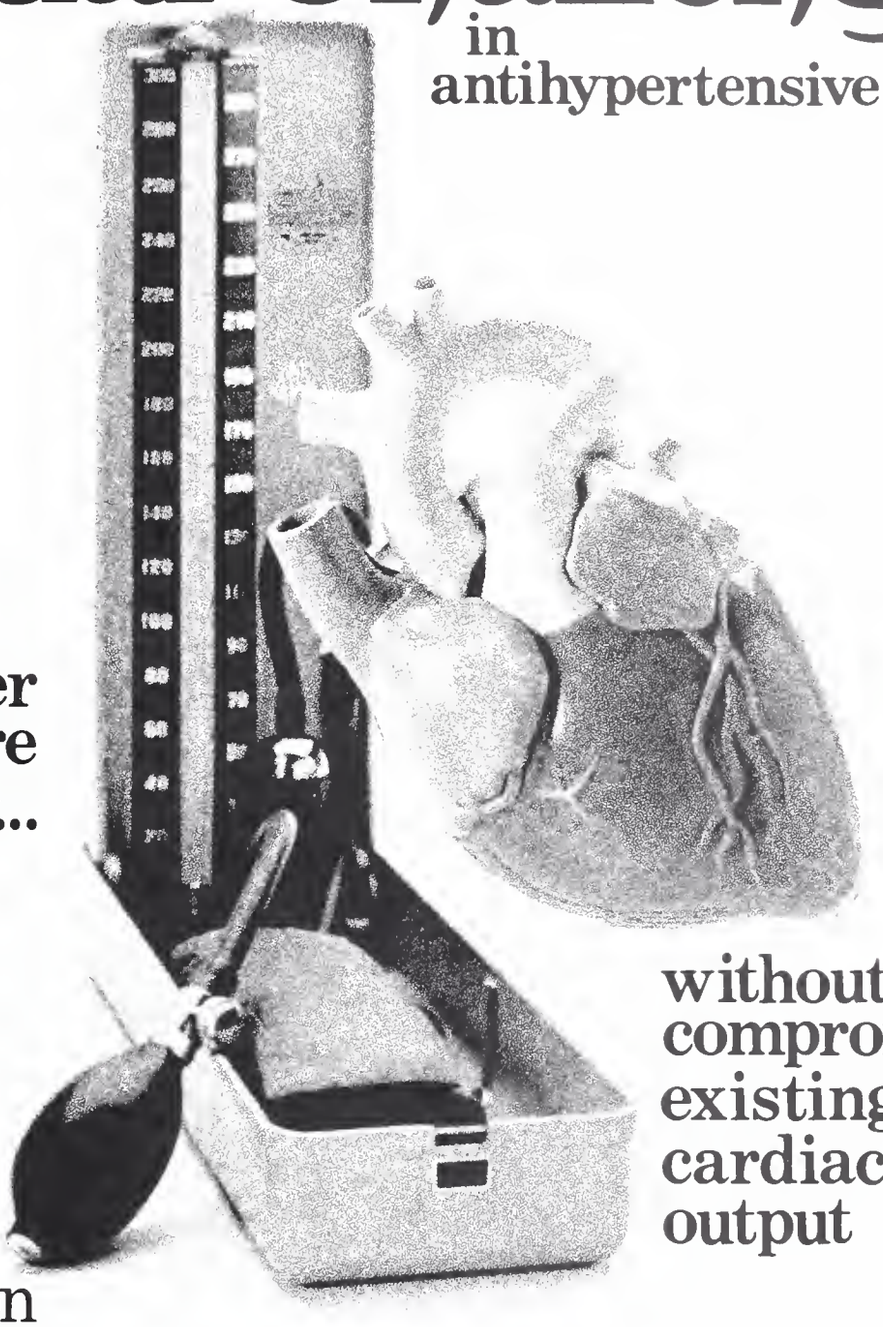
1:30 PM **Restoration of Facial Abnormalities**— David E. Schuller, M.D., Assistant Professor of Otolaryngology, The Ohio State University College of Medicine

2:15 PM **Laryngeal Diseases of Children**— Robin T. Cotton, M.D., Associate Professor of Otolaryngol-

(continued on page 172)

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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07(707)

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Enrollment: Limited to 35

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Annual Meeting Courses *(continued)*

Otolaryngology Continued

ogy and Maxillofacial Surgery, University of Cincinnati College of Medicine.

3 PM Break

3:30 **And So to Smile Again— the Facial Nerve—** John W. Ray, M.D., Clinical Assistant Professor of Otolaryngology, The Ohio State University College of Medicine

Tuesday

9 AM **Audiology in Ohio—** William Melnick, Ph.D., Associate Professor of Otolaryngology, The Ohio State University College of Medicine

9:30 AM **Stapes Surgery: Long Term Results:—** Mendel Robinson, M.D., Clinical Assistant Professor of Surgery in Otolaryngology, Division of Biomedical Sciences, Brown University, Providence, Rhode Island

10:15 AM Break

10:45 AM **Current Concepts of Stapes Surgery—** Howard P. House, M.D., Clinical Professor of Otolaryngology, University of Southern California School of Medicine, Los Angeles

12 NOON Lunch: Sheraton-Columbus

1:30 PM Panel Discussion: **Stapes Surgery, 1977—** John W. Ray, M.D., Clinical Assistant Professor of Otolaryngology, The Ohio State University College of Medicine, moderator; Howard P. House, M.D., William H. Lippy, M.D., Warren; Howard W. Lowery, M.D., Clinical Associate Professor of Otolaryngology, The Ohio State University College of Medicine; and Mendel Robinson, M.D.

2:20 PM **Ossicular Problems—** Howard P. House, M.D.

3 PM **Tympanic Membrane Reconstruction: A New Technique—** Mendel Robinson, M.D.

3:45 PM **Practical Use of Chemotherapy in Head and Neck Tumors—** (Speaker to be selected.)

PATHOLOGY

CME Hours: 5 Category I
Date: Tuesday, May 17
Time: 9 AM-4:30 PM
Sponsor: OSMA Section on Pathology and the Ohio Society of Pathologists
Course Director: *Brooks Hurd, M.D.*

9 AM **Clinical Laboratory Testing in Physician's Offices: Costs, Benefits, and Legislative Impacts—** Brooks Hurd, M.D., Columbus, Moderator; Frank C. Coleman, M.D., Tampa, Florida (An Overview of Federal Programs Affecting Physician Office Testing); Noel S. Lawson, M.D., Detroit, Michigan (On the Assurance of Being Correct); and Frederick E. Light, M.D., Cleveland (Screening Procedures for Routine Patient Examination: Expense and Reward); Paul E. Schneider, Ph.D., Biodynamics/BMC, Indianapolis, Indiana (Availability and Reliability of Test Systems for Physicians' Offices); Brian J. Harrington, Ph.D. Mercy Hospital, Toledo (Office Bacteriology— Recognizing the "Bugs")

Questions and Answers

11:30 AM Business Meeting— Ohio Society of Pathologists

1:30-4:30 PM **The Practice of Pathology in View of Recent and Pending Legislation—** Alfred S. Ercalano, Washington, D.C. (State of the Art— Current Status of Proposed and Recently Enacted Federal Legislation); Herbert Derman, M.D., Columbus (Impact of Legislation on Quality Cost and Productivity in the Clinical Laboratory)

Break

Panel Discussion: **Impact of Federal Legislation on Patterns of Pathology Practice and Contractual Arrangements**

Small Hospital Practice in a Group with a Private Laboratory Base— H. B. Davidson, Jr., M.D., Columbus

The Pathologist in a Small or Medium-Sized Hospital— Robert E. Schulz, M.D., Wooster

The Complex of a Large Hospital Combined with a Private Laboratory— Daniel J. Hanson, M.D., Toledo

The Large Private Clinic-Hospital Complex — Lawrence J. McCormack, M.D., Cleveland

4 PM Questions and Answers— Mr. Ercalano, Drs. Davidson, Hanson, McCormack and Schulz

PHYSICAL MEDICINE AND REHABILITATION

Topic: Physical Modalities: Past and Present
CME Hours: 3 Category I
Date: Tuesday, May 17
Time: 1:30-4:30 PM
Sponsor: OSMA Section on Physical Medicine and Rehabilitation, and the Ohio Society of Physical Medicine and Rehabilitation

1:30 PM **Keynote Speaker:** Sidney Licht, M.D., Coral Gables, Florida. Dr. Licht is Curator, Physical Medicine Collections, Yale University; Clinical Professor, University of Miami School of Medicine; Consultant in Physical Medicine and Rehabilitation, VA Hospital, Miami, Florida; Consultant in Physical Medicine and Rehabilitation to University of Vermont and the Beth Israel Hospital of New York City.

Discussion following Dr. Licht's presentation.

PSYCHIATRY

Title: Current Perspectives in Health Care and Psychiatry
CME Hours: 3 Category I
Date: Monday, May 16
Time: 12 NOON-6:30 PM

Sponsor: OSMA Section on Psychiatry and Neurology and the Ohio Psychiatric Association
Course Director: *Roslyn Seligman, M.D.,* Cincinnati, Ohio Psychiatric Association
12 NOON Lunch and Business Meeting
1:30 PM **The Psychiatrist and Treatment Adherence**— Barry Blackwell, M.D., Department of Psychiatry, Wright State University, Dayton
1:50 PM Discussion
2 PM **Sleep Pathologies: A Threat to Life**— Milton Kramer, M.D., Veterans Administration Hospital, Cincinnati
2:20 PM Discussion
2:30 PM **30-Year Retrospective on the Changes in Delivery of Psychiatric Services in a Small Community**— Edward Kezur, M.D., and Marian Parish, M.S.W., Ft. Hamilton Hughes Memorial Hospital Center, Hamilton
2:50 PM Discussion
3 PM Break
3:30 PM **HMO Psychiatry: An Uncharted Territory** — Theodor Bonstedt, M.D., Cincinnati
3:50 PM Discussion
4 PM **No Balm in Gilead? An Overview of Mental Health Beliefs in a Time of National Renewal**— John Kuehn, M.D., Canton
4:20 PM Discussion
4:30 PM **Pediatric Emergency Psychiatry: The Entry Phase**— Helen Tucker, M.D., and Michael Farrell, M.D., Cincinnati
4:50 PM Discussion
5 PM **Psychiatric Accountability: A National Perspective**— Richard Dorsey, M.D.
5:20 PM Discussion

RHEUMATOLOGY

Topic: Clinical Evaluation and Treatment of the Rheumatic Diseases
Date: Monday, May 16
Time: 1:30-5 PM
Sponsor: OSMA Section on Rheumatology and the Ohio Rheumatism Society
Course Director: *Richard H. Turner, M.D.,* Columbus

1:30 PM **History of Physical Examination in Differentiating the Rheumatic Diseases**— Robert Sheon, M.D., Toledo
1:50 PM **Synovial Fluid Analysis and Synovial Biopsy** — Robert Zipf, M.D., Columbus
2:10 PM **Radiology and Nuclear Medicine**— (Speaker to be selected.)
2:30 PM **Arthroscopy: Synovial Diseases**— Lanny Johnson, M.D., East Lansing, Michigan
2:50 PM Discussion
3:10 PM Break
3:30 PM **What is New in the Medical Management of Adult Rheumatic Disease?**— Norman O. Rothermich, M.D., Columbus
3:50 PM **What is New in the Medical Management of Juvenile Rheumatic Disease?**— Jack Bass, M.D., Columbus
4:10 PM **What is New in the Orthopedic Management of Rheumatic Disease?**— Edward Miller, M.D., Cincinnati
4:30 PM Discussion

Open Session

"Public Attitudes Toward Health Care and Malpractice Solutions" will be presented at a general session of the OSMA Annual Meeting, Monday, May 14, from 1:30 to 3:30 PM. The presentation will be conducted by Roger Blackwell, Ph.D., Vice President of Management Horizons, Inc., the consulting firm which recently conducted a public opinion survey for OSMA as part of the Malpractice Research Projects.

Dr. Blackwell will discuss how American lifestyles influence public attitudes toward physicians, health care, and malpractice. Key findings of the study relating to physicians and malpractice will be presented as well as conclusions concerning actions physicians, their spouses, and other health professionals can take as a result of the study.

Members of the Auxiliary of the OSMA as well as physicians are encouraged to attend this session. For further information, contact the OSMA Department of Continuing Medical Education.

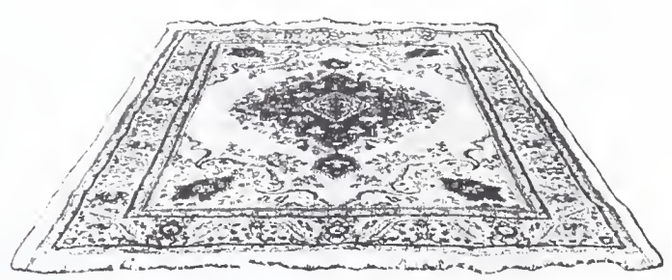
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Doctors, Patients, and the Social Security Disability Programs

John E. Hastings, M.D.

The purpose of this article is to explain some of the ramifications and complexities of the Disability Program, to assure the physician that he and his services are needed now more than ever before, and that tax dollars are being spent in the Disability Program carefully and judiciously. The Disability Program conducted by the Social Security Administration cannot function without the help of doctors. The more the physicians cooperate, the better the quality of the decision making and the fairer the decision.

There has been some type of Social Security Program in existence since 1935. At first, Social Security simply legislated enforced savings for working people supplemented by contributions by employers. These joint savings were supposed to provide a basic or survival income for the worker after age 65 years.

In 1954, Congress recognized that many workers were forced to retire before age 65 years because of crippling disabilities, thereby becoming dependent on their families, private institutions, or public welfare. Therefore, in 1956, the Disability Program of the Social Security Administration was expanded. The Bureau of Disability Insurance is a part of the Social Security Administration which, in turn, is a subdivision of the Department of Health, Education, and Welfare. The Bureau of Disability Insurance has central offices in Baltimore.

As a result of the legislative expansion of the disability program, changes in the law provided for cash benefits to workers if and when disabled. The problem became who would decide who was and who was not disabled. Obviously, doctors had to be consulted and recruited to help in the decision making; and standards for decision making had to be agreed upon and formulated.

This recruitment of physicians still continues. Physicians are being asked to participate, to examine claimants, and to provide reports of examinations. Not only are examinations and reports required, but also concise reports that describe impairments are necessary. For instance, it is not unusual to see a report which may say something as vague as "This man complains of his hearing and cannot hear very well. He is 100 percent disabled." Obviously, this claimant cannot receive a fair decision until a satisfactory examination has been performed and reported. The same is true in regard to any impairment which prevents an individual from supporting himself.

The Bureau of Disability Insurance is basically concerned with two provisions. One is the Title II Disability Insurance Program which was passed by Congress in 1954 and implemented in 1955. The other is the Title XVI, or Supplemental Security Income Program, which was established by law in 1972 and implemented in January 1974.

Applicants for Title II disability benefits are people, their dependents, or survivors who have (1) been employed in work covered by the Social Security Act and (2) allege that they are disabled and unable to work.

Applicants for Title XVI benefits are those who have established that they are needy and, in addition, are claiming to be disabled. The Supplemental Security Income (Title XVI) claimants may never have worked. In fact, they may be children who have such severe impairments that they are not able to attend school or are not able to relate to other children in a normal manner and, therefore, can be expected to grow up with a substantial handicap.

No matter whether the claim is to be developed under the Title II or Title XVI provision, the next step after filing an application is the accumulation of medical information. This is where the physician enters the process.

Disability determinations are made to a great extent upon the information supplied by the doctors. The administration prefers to use the information from the primary source whether it be from a treating physician, hospital, clinic, or other institution. The medical evidence, to be acceptable, must describe the impairment so clearly than an independent examiner reading the reports would reach a similar decision.

A physician who receives a letter requesting medical information on a patient should send whatever pertinent information he has as promptly as possible to the state agency. If he has no record of any disabling illness, he should report that also. Disabilities must be of a chronic nature which can be expected to last 12 months or longer or terminate in death, and be so severe that they prevent the claimant from engaging in substantial gainful activity.

Disability determinations are made within each of the states. In Ohio, this is done by the Bureau of Disability Determination, Rehabilitation Services Commission. The determinations are based on evidence documented from information submitted by other doctors who have actually examined the claimant and are made by a team of physicians and trained disability examiners. The doctor who, with the disability examiner, makes the decision to allow or deny the claim never sees the patient. This process may seem needlessly long and impersonal. However, effort is made to keep the relationship between the claimant and the adjudicating team as impersonal as possible. Any hint of personal pressure or emotional reaction entering into consideration of the degree of impairment is avoided.

Dr. Hastings, Columbus, Chief Medical Consultant Bureau of Disability Determination, State of Ohio Rehabilitation Services Commission.

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Centennial Celebration for Cincinnati OB/GYN Society

Linda A. Jacobson

The Cincinnati Obstetrical and Gynecological Society celebrated its 100th anniversary during September. Honored guests included the presidents-elect of the national societies devoted to obstetrics and gynecology: Richard T. F. Schmidt, M.D., Cincinnati, American College of Obstetricians and Gynecologists; Raymond H. Kaufman, M.D., Houston, Central Association of Obstetricians and Gynecologicts; Clyde L. Randall, M.D., Baltimore, American Gynecological Society; and J. Donald Woodruff, M.D., Baltimore, American Association of Obstetricians and Gynecologists.

Also present were University of Cincinnati President Warren Bennis; University of Cincinnati College of Medicine Dean Robert S. Daniels, M.D.; Cincinnati Historical Society President John A. Diehl; Academy of Medicine of Cincinnati President Stanley A. Lucas, M.D.; Cincinnati Mayor Bobbie Sterne; and Director of the University of Cincinnati Medical Center Stanley B. Troup, M.D.

Paul J. Haas, M.D., Retiring President of the Society, conducted the business portion of the meeting. Dr. Haas noted that each member of the Society is devoted to academic excellence as is evident in the requirement that a paper be written and submitted to the Society for membership consideration. Dr. Haas also praised the visiting professor program sponsored by the Society. With the help of the teaching hospitals of Cincinnati, a physician is invited, once a month for seven to eight months a year, to come to Cincinnati to lecture. In addition, grand rounds are alternated between participating hospitals.

Midway into the evening, Dr. Haas passed the gavel to President-Elect Clarence R. McLain, Jr., M.D. Dr. McLain noted in his inaugural remarks that if the field of obstetrics and gynecology is going to meet the demands of the future, it must attract the brightest and most compassionate students to the specialty. He indicated that three factors will influence what the practice of the specialty will be like in the next decade. The first factor is the



Left to right: Paul J. Haas, M.D., passes the gavel to Clarence R. McLain, Jr., M.D., at the Society's meeting.



Arthur G. King, M.D., Society Historian, presents a copy of his book to Cincinnati Mayor Bobbie Sterne.

increasing interest in this field. Seven percent of all medical school graduates are entering the field each year; and, therefore, the number of specialists in the field is increasing due to the increasing number of graduates. Second, the choices of areas of the field in which to practice are numerous, with many physicians feeling an obligation to fulfill social needs. Thirdly, the specialty will be influenced by the increasing need of patients for advice as well as treatment.

Arthur G. King, M.D., Cincinnati, Society Historian, spent some time giving a brief history of the Cincinnati Obstetrical and Gynecological Society. He noted that George McClure, M.D., is the oldest living member of the Society, having entered membership in 1930. Dr. King was appointed permanent historian somewhat later in 1938.

His most recent written work is *The Cincinnati Obstetrical and Gynecological Society 1876-1976,* written in honor of the centennial celebration. Copies of this work, dedicated to "(his) wife, Marthe, and to all other obstetricians' wives, whose seldom recognized domestic sacrifice contribute so largely to the good professional care of the parturient woman," were distributed at the meeting.

The following is an excerpt from Dr. King's book:

In the autumn of 1876 a dozen physicians practicing in and around Cincinnati formed a society devoted to "the promotion of knowledge in all that pertains to Obstetrics and Diseases peculiar to women." Boston had had an obstetrical society since 1861, New York since 1864, and Philadelphia since 1868. Thus the Cincinnati Obstetrical Society was the fourth of its kind in the United States. . .

In the one hundred years since its founding the Cincinnati Obstetrical and Gynecological Society has gone through several phases of character and productivity. The history, as recorded in the minutes, has made possible an analysis of some of the factors involved, and these include the interplay of the individual members with the scientific and sociologic events of the times.

(continued on page 178)

One Hundred Years *(continued)*

There have been a total of 215 people admitted over the years and the Society's thinking and activity have been shaped by the personalities of some of these.

Among the founders were physicians of varied degrees of training, skill, intelligence and energy. Some were able to express themselves well, and by publishing their observations and ideas were able to reach a large audience and thus add dramatically to the world's knowledge. Others were content to do their best for their own patients, and as Chauncy D. Palmer advised, "bring with them to our monthly meetings their mite offerings of experience." Thaddeus A. Reamy, Joshua W. Underhill, Jacob Trush, and, of course, Marmaduke Burr Wright were the giants who not only set an example of presenting carefully prepared and authoritative contributions, but stimulated and led others in the same direction. They achieved national recognition for themselves and for Cincinnati and established a philosophy of obstetric-gynecologic practice which was distinct, progressive and satisfying.

However, it tended to become too satisfying, static and less dynamic. With the rapid advances in our discipline which came out of Europe, it was Gustav Zinke and C. A. L. Reed, joined by Sigmar Stark and his exquisite and meticulous surgical technique, who brought to Cincinnati the newer philosophies and experimental attitudes to challenge the Establishment. For a while there was an amalgam of the old and the new from which Cincinnati was able to enjoy capable performance by many able practitioners. Each of the several medical schools in the city had some distinguished faculty members and the fusion of the schools to form the University of Cincinnati College of Medicine provided a large pool of doctors. But it appears that the medical inbreeding process which followed the turn of the century led slowly to a loss of vigor that approached stagnation.

The arrival in Cincinnati of James Mortimer Pierce turned the obstetrical-gynecological perspective outward, and the younger men who followed him dared to implement new concepts, perhaps somewhat stimulated by the keenly honed intellect of J. Hofbauer. The Cincinnati Obstetrical and Gynecological Society once again became part of the American mainstream of the discipline, and its members were recognized by regional and national societies. Our members became influential in the formation and expansion of the American College of Obstetricians and Gynecologists and equally effective in modernizing the philosophy of the College of Medicine of the University of Cincinnati.

The history of the Cincinnati Obstetrical and Gynecological Society proves that the basic elements of the various problems existing for one hundred years remain the same the more the circumstances change. Questions which plagued the Founders are still before us. For example: Is the Society to be an elitist group which by its influence will raise the general standards of obstetrics and gynecology in the city or is it to be an informal educational institution to supplement textbook and Medical College training? Is the main thrust of the education to improve the performance of the already skilled members, to stimulate them to do research or distill current knowledge and produce papers for criticism, or is it to increase the number of skilled practitioners? The recurrent discussions of requiring an admission thesis and of having members give papers at certain intervals were addressed to that problem.

How far are we to go with the phrase in our constitution, "all that pertains to obstetrics and disease of women?" Does "all" mean limited to purely technical and professional matters or do our purposes include sociologic difficulties such as sex education, abortion, infant adoption practices, rape, the status of women in the profession, and the working conditions and remuneration for women in general? How large a part should we play in the ever-changing attitude of women toward pregnancy and the techniques of parturition? To what extent should our Society try to modify hospital organization and function to provide better obstetrical and gynecologic care? Can we stretch our interpretation to justify fighting to protect future good medical care of women by defending ourselves from the bureaucratic throttling of our initiative in that direction?

For a hundred years these and other questions have appeared in the minutes of the Society in one form or another. The answers found by each generation have often been reversed by the next generation and still later modified to reflect the attitudes of the earlier years. While the younger members are thus often condemned to relearn the old lessons the very process has strengthened the Society. It has given us flexibility and a capacity to meet changing conditions and ideas and even to project ourselves into the future. We have abandoned parochialism and have accepted the responsibility of evaluating a wide variety of choices. We are able to synthesize different medical philosophies, to blend the traditional with the experimental and the conservative with the daring, not only in strictly professional matters but in organization and goals.

To be truly positive and constructive in our approach to gynecology we must change our definition of that word. Perhaps we should consider changing our constitution to substitute for the negative phrase, "Diseases peculiar to women" the concept of the total woman rather than just her ailments. For the next century the object of the Cincinnati Obstetrical and Gynecological Society should be the promotion of knowledge in all that pertains to obstetrics and the medical welfare of women.

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news

Consent Form Needed For Polio Vaccination

Ohio Department of Health

Due to contractual agreements between the Lederle Company (the only manufacturer of polio vaccine) and the federal government, it will be necessary that an informed consent form be filled out on every patient receiving vaccine at a public clinic. This will also affect some physicians who receive free polio vaccine distributed by local health departments. They will have to sign a Physician's Certification Form that states that they will exercise individual medical judgment on the need for the patient to be immunized or will have the patient sign the informed consent form. This form has been distributed by the Ohio Department of Health to local health departments.

The Ohio Department of Health realizes the importance and supports completely the concept of informed consent; however, it does have some questions as to this method of informed consent. The Department is especially worried that the Physician's Certification Form may alienate a number of physicians who provide a special service by using the Department's free vaccine. The Department asks everyone involved to be patient and cooperate with these particular restrictions. It is attempting to get clarification as to the need of the Physician's Certification Form; but until these questions are clarified, it will be necessary to follow the Lederle Company's stipulations.

Workers' Compensation Benefits

The following Workers' Compensation Benefits cover injuries, death, or occupational diseases contracted on or after January 1, 1976.

Temporary Total (ORC 4123.56)

Maximum Benefit: 66⅔ percent of his average weekly wage for the first 12 weeks. Thereafter, 66⅔ percent of his average weekly wage, not to exceed the statewide average weekly wage (1977: $198, 1976: $186).

Minimum Benefit: 33⅓ percent of statewide average weekly wage (1977: $66, 1976: $62), or worker's actual average weekly wage if less than 33⅓ percent of statewide average weekly wage.

Temporary Partial (ORC 4123.57A)

Maximum Benefit: 66⅔ percent of worker's impairment of earning capacity due to the allowed injury or occupational disease. This should not exceed the statewide average weekly wage (1977: $198, 1976: $186) up to an aggregate of $12,500.

Minimum Benefit: None

Permanent Partial (ORC 4123.57B)

Maximum Benefit: 66⅔ percent of worker's average weekly wage, not to exceed $56 per week.

Minimum Benefit: None

Scheduled Losses (ORC 4123.57C)

Maximum Benefit: 66⅔ percent of worker's average weekly wage, not to exceed 50 percent of the statewide average weekly wage (1977: $99, 1976: $93).

Minimum Benefit: 25 percent of the statewide average weekly wage (1977: $49.50, 1976: $46.50).

Permanent Total (ORC 4123.58)

Maximum Benefit: 66⅔ percent of worker's average weekly wage, not to exceed 66⅔ percent of the statewide average weekly wage (1977: $132, 1976: $124) except as provided in Division B of ORC 4123.58.

Minimum Benefit: 50 percent of the statewide average weekly wage (1977: $99; 1976: $93), or worker's actual average weekly wage if less than 50 percent of the statewide average weekly wage.

Death — Wholly Dependent Survivors (ORC 4123.59B)

Maximum Benefit: 66⅔ percent of worker's average weekly wage, not to exceed the statewide average weekly wage (1977: $198, 1976: $186). Benefits are available provided that the death is due to an injury received or an occupational disease first diagnosed after January 1, 1976, or that the claimant is receiving total disability compensation at the time of his death. Otherwise, the maximum is 66⅔ percent of the statewide average weekly wage.

Minimum Benefit: 50 percent of the statewide average weekly wage (1977: $99, 1976: $93).

Death — Partly Dependent Survivors (ORC 4123.59C)

Maximum Benefit: 66⅔ percent of the worker's average weekly wage, not to exceed 66⅔ percent of statewide average weekly wage (1977: $132, 1976: $124).

Minimum Benefit: None.

A. H. Robins Company Makes Contribution to OSMA

A. H. Robins Company, Richmond, Virginia, has contributed $200 to the OSMA for use in furthering professional or educational programs of the Association's choice. Company president William L. Zimmer, III, said in making the presentation: "As we begin a new year, the management, representatives and employees of

A. H. Robins send their best wishes and at the same time assure you of our support of your efforts on behalf of medicine. . . . Please express our appreciation to your officers and members of your organization as they continue to serve the profession in Ohio."

OSMA Executive Director Hart F. Page indicated that the funds would be used by the OSMA Department of Continuing Education. Mr. Page stated: "Since 150 hours of continuing medical education are now required of each holder of an Ohio medical license, our efforts in this area are a heavy demand on the resources of the Association and we are grateful to you for your interest and assistance."

A. H. Robins has also supported Ohio physicians through the advertising it places in *The Journal.*

Dividend Declared for OSMA Group Term Life Plan

OSMA President George N. Bates, M.D., announced that a 43 percent dividend has been declared for OSMA members, dependents, and employees who participate in the Association's Group Term Life Plan. This sizable dividend, covering the policy year ending August 31, 1976, will be used to reduce the March 1, 1977, semi-annual premium. Turner and Shepard, Inc., the plan administrator, noted that this dividend was declared even though the rates had been reduced by ten percent last year.

OSMA members not enrolled in this Group Term Life Insurance Plan are reminded that participation is one of the many advantages of OSMA membership. The maximum amount of coverage available is $100,000.

College of Chest Physicians Invites Abstract Submission

The Scientific Program Committee of the American College of Chest Physicians (ACCP) invites submission of abstracts for presentation at the ACCP 1977 Annual Meeting, October 30 to November 3. Membership in the ACCP is not a prerequisite to participation in the program. However, material submitted must not be published or presented elsewhere prior to November 3, 1977. Abstracts covering topics in circulation, respiration, thoracic and cardiovascular surgery, and related systems should not exceed 150 words in length. An original and four copies should be provided. Include the title of the paper, full first and last names of the authors, and the name of the institution where the work was performed. The full address where correspondence should be directed and identification of the individual who will present the paper should also be provided.

Submission deadline is May 1, 1977. Send abstracts to: Stephen M. Ayres, M.D., Chairman, Scientific Program Committee, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

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obituaries

JOHN G. ANDERSON, M.D., Lynchburg; University of Cincinnati College of Medicine, 1930; age 73; died January 4; member OSMA and AMA.

EDWARD F. BUYNISKI, M.D., Cincinnati; Tufts University School of Medicine, Boston, Mass., 1946; age 64; died August 15, 1976; member OSMA and AMA.

FRED G. CALLAWAY, M.D., Marysville; Eclectic Medical College, Cincinnati, 1915; age 86; died January 24; member OSMA and AMA.

ROBERT CRUDGINGTON, M.D., Cincinnati; University of Cincinnati College of Medicine, 1924; age 83; died July 28, 1976; member OSMA and AMA.

FRANK E. CUNNINGHAM, M.D., Cincinnati; Georgetown University School of Medicine, Washington, D.C., 1931; age 72; died January 22; member OSMA and AMA.

WALLACE S. DUNCAN, M.D., Cleveland; University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1921; age 80; died January 12; member OSMA and AMA.

HARRY GOLDBLATT, M.D., Cleveland; McGill University Faculty of Medicine, Montreal, Quebec, Canada, 1916; age 86; died January 6; member OSMA and AMA.

GASTON HANNAH, M.D., Delray Beach, Florida; University of Cincinnati College of Medicine, 1933; age 70; died January 5; member OSMA and AMA.

JOSEPH M. HEIDELMAN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1941; age 71; died March 14, 1976; member OSMA and AMA.

ANDREW KLEPNER, M.D., Bowling Green; Medizinische Fakultat der Universitat Bern, Bern, Switzerland, 1957; age 57; died January 10; member OSMA and AMA.

WILLIAM LIEBSCHNER, M.D., Sandusky; University of Rochester School of Medicine and Dentistry, Rochester New York, 1936; age 67; died December 29, 1976; member OSMA and AMA.

EUGENE J. McCAFFREY, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, Missouri, 1943; age 58; died December 29, 1976; member OSMA and AMA.

C. C. PINKERTON, M.D., Topeka, Kansas; University of Illinois College of Medicine, Chicago, Illinois, 1915; died January 24; member OSMA and AMA.

IRL CEPHAS RIGGIN, M.D., Richmond, Virginia; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1917; age 84; died January 19; member OSMA and AMA.

MILTON STRAWBRIDGE, M.D., Sarasota, Florida; Ohio State University College of Medicine, 1925; age 76; died December 28, 1976; member OSMA and AMA.

Harland Howe, M.D., was from Toledo not Akron as listed in the February issue. *The Journal* regrets the error.

it is anticipated that other hospitals in northwest Ohio may form similar affiliations with MCO during the next few years. Although the Medical College of Ohio Hospital will continue to expand to a total of 258 beds by 1980, when our new clinical facility will be operational, other facilities and clinical faculty will be required for the educational, research, and service programs necessary to provide an optimal level of medical care for the people of northwest Ohio. This will require permanent, close relationships with associated and affiliated hospitals and the teaching faculty in those hospitals, as well as a large number of physicians in the community. The basis has been laid for solid, cooperative enhancement of teaching programs in the northwest Ohio medical community. However, much more effort will be made by the MCO students, faculty, and administration to broaden the base of teaching in the community. The key to the future success of the teaching programs of the MCO and its associated and affiliated hospitals will be cooperative effort.

School and Community Cooperation

Man has succeeded as a species because he is the most cooperative and flexible species on earth. Scientists in general, and physicians in particular, have always worked together for the common cause of promoting scientific developments which improve the health care of human beings in spite of many different individual and personal points of view and vested interests. In the future, all medical schools will probably require a similar cooperative effort for the survival of the medical school because no hospital or school on its own will be able to afford the costs of increasing technologic advancements, instead, this cost must be borne by entire regions of population. The older schools' investments are largely intramural; and increasingly, they are developing educational programs in the community. The newest of schools have no intramural, clinical investments making it impossible to develop any of their new academic clinical programs under the close supervision of their intramural clinical faculty, but, instead, all such clinical programs must be developed in the community. The Medical College of Ohio must rely on the community for its total health education thrust but, fortunately, has a small intramural clinical program. It is our opinion that all medical education will be moving in this direction during the next decade. This will be accomplished through the cooperative, well-organized effort of relatively small, full-time faculty, large numbers of part-time and volunteer faculty, and other community hospitals, agencies, and facilities.

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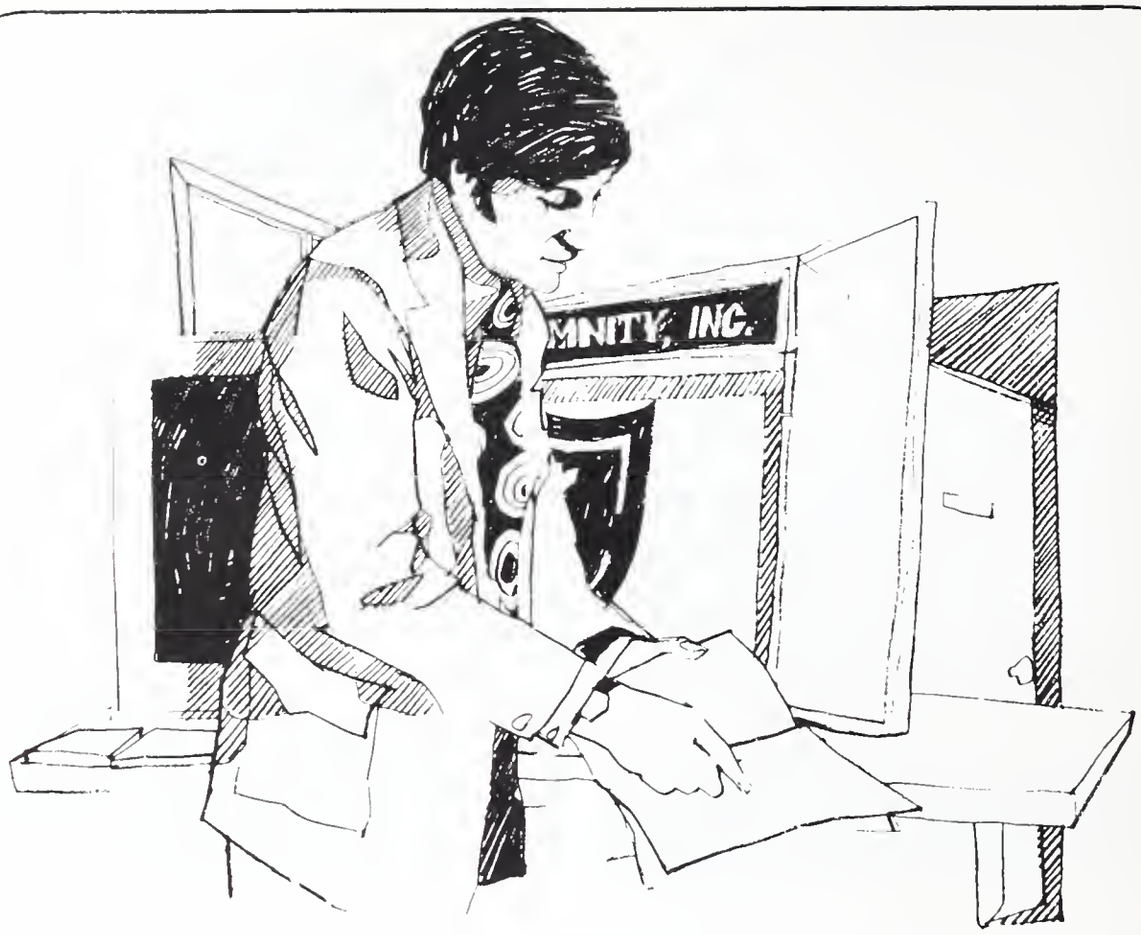
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WANTED BY INTERNIST AND GASTROENTEROLOGIST WITH BUSY PRACTICE: Board-certified or eligible physician with subspecialty in cardiology or pulmonary diseases, licensed in State of Ohio. Must be available immediately. Qualifications should include desire to work hard. Guaranteed gross income of $50,000 per annum besides fringe benefits which also include all overhead expenses and malpractice insurance. Reply Box 781 c/o Ohio State Medical Journal.



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FAMILY PRACTICE MEDICAL POSITIONS AVAILABLE: Family practitioners and director of family practice center wanted. Solo, group or association practice available. Both existing or new practice opportunities available. 250-bed, general/regional hospital within walking distance of offices with privileges available. Hospital is an exceptionally well-equipped, general, short-stay facility with excellent medical staff that is committed to the family practice/primary care approach. Industry and agriculture provide sources of income to 40,000-70,000 people living in city and county. Total area population 250,000. Excellent schools and a branch of Ohio State University. Contact Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and 250-bed general hospital with privileges available. (See FAMILY PRACTICE POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

EMERGENCY PHYSICIANS: Cleveland, Ohio. Opportunity to pursue career in long-established, compatible professional group providing emergency services to three hospitals in Northeast Ohio. Enjoy four weeks vacation, two weeks professional development, and a superior starting income with outstanding ancillary benefit plan. An Ohio license is prerequisite and membership in ACEP is desired. We are most interested in career-oriented individuals desirous of growth, security, and professional enhancement. If qualified and interested, please call Ronald Kimes, Group Manager, Emergency Associates, Inc. For further information and a personal interview phone: 216/461-5255, Monday through Friday, 8 AM to 5 PM.

RADIOLOGIST: An associate radiologist is needed in hospital practice of radiology including nuclear medicine. Northcentral Ohio, rural college town. Financial arrangement negotiable. Ample time for vacation and professional education. Write: Radiologist, P.O. Box 527, Ashland, Ohio 44805.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third partner to practice. New facility. Excellent hospital within walking distance. (See **FAMILY PRACTICE POSITION AVAILABLE** ad this issue for more detailed information.) Contact Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

PHYSICIAN WANTED: To assume duties as a general practitioner on beautiful Put-in-Bay Island. Ideal for semi-retirement. This is a summer resort area, but does provide a doctor with a good living the year around. Modern home, offices, light, heat, and power furnished by the community. Contact Gus Cooper, Township Clerk, P.O. Box 218, Put-in-Bay, Ohio 43456. Phone: 419/285-3394.

FAMILY PHYSICIAN: FAAFP, mature, desires association with solo practitioner looking forward to semi-retirement, or small group, to practice six to nine months per year, sharing expenses and time off. Reply Box 787, c/o Ohio State Medical Journal.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

INDUSTRIAL PHYSICIAN FULL-TIME: No previous industrial experience required. Acceptable following one-year internship or residency. Normal in-plant medical facility available. Excellent starting salary and large company benefits. Apply: Chief Physician, Lorain Assembly Plant, Ford Motor Company, 5401 Baumhart Road, Lorain, Ohio 44052.

PRACTITIONERS: TIRED OF LONG HOURS? Have you considered an exciting, hospital-based specialty? We have one, and an excellent training program in Rehabilitation Medicine. Two vacancies for July 1977. Write Dr. C. Long, CWRU-affiliated Program, Highland View Hospital, 3901 Ireland Dr., Cleveland, Ohio 44122.

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EXPERIENCED FAMILY PHYSICIAN: Available as locum tenens, minimum 2 months. Reply Box 788, c/o Ohio State Medical Journal.

OFFICE FOR RENT: COLUMBUS. New office building: 5 min. from Mercy Hospital, 10 min. from Mt. Carmel Hospital, and 10 min. from Grant Hospital. Will tailor office to requirements. Ample off-street parking; bus stop on corner. Air conditioned. Phone days: Robert E. Horowitz, 614/444-1151.

PHYSICIAN'S ASSISTANT: Age 35, interested in working for private physician or clinic in Cincinnati/northern Kentucky area. Nine years' previous medical experience; 6 years as lab tech, 3 years as medical secretary; competent, dependable, NBME certified. Available March 1. Contact Juanita Becker, 2824 Westknolls Lane, Cincinnati, 45211.

(**Editor's Note:** *The Journal* presents the above classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.)

NEEDED, PHYSICIANS in all specialties throughout Ohio to evaluate patients applying for disability under the Social Security Disability Programs. If you are interested, please contact John E. Hastings, M.D., Chief Medical Consultant or Mr. James Wallace, Deputy Administrator for Social Security. Phone 800/282-9330, ext. 7457 or 6393.

WANTED: PHYSICIANS — ALL SPECIALTIES: As search consultants in the health care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals, and other organizations in the health care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. **LEPINOT ASSOCIATES INC., 702 ABBOTT ROAD, EAST LANSING, MICHIGAN 48823.**

OHIO — EMERGENCY ROOM PHYSICIAN: Full time, 4 or 5 days per week. Near Cleveland, Akron, and Youngstown. Hourly rate. Contact S. Sami Solu, M.D., Chief, Robinson Memorial Hospital, Ravenna, Ohio 44266. Phone: 216/297-0811.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone 216/946-4546.

FAMILY PRACTITIONERS, OB-GYN, AND GENERAL INTERNISTS: Health Central, a new, prepaid, group practice, seeks progressive physicians eager to assist with the development of an innovative health care delivery system. Must be committed to preventive care and physician group practice. Should have a strong interest in working closely with other health care professionals and consumers. Salary range $35,000-$45,000, with excellent fringe benefits. University town with medical schools. Located in state capital; community of 250,000 served by four hospitals. Contact Robert Chesky, M.D., Medical Director, Health Central, 3401 East Saginaw, Suite 109, Lansing, MI 48912.
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PSYCHIATRISTS: City/County of 66,000 has critical need of a psychiatrist. Will affiliate with MH Area Counseling Center. Excellent salary, benefits and physical facilities. (See FAMILY PRACTICE MEDICAL POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

THREE BOARD-CERTIFIED FAMILY PHYSICIANS looking to recruit family physician graduate or board-qualified or certified family physician as an associate in a semi-rural small town, group practice. Progressive community; local liberal arts college; excellent local community hospital; and 35 miles from Columbus, Ohio. A very good setting in which to practice, live, and raise a family. Contact Granville Medical Center, Inc., Granville, Ohio 43023, phone 614/587-0115.

PHYSICIAN NEEDED: Dayton, Ohio. Office— 7 rooms, ground level, intruder-proofed, caretaker in apartment above. Treatment rooms complete with all diagnostic equipment, Picker x-ray, fluoroscope, minor surgery instruments. Laboratory with microscope with mechanical stage. Sanborn electrocardiograph. You will need your own bookkeeping system. A five-figure income your first year. Area: three men retired plus one who died, all with large practices. They were all good men and are missed. A young man, well trained, willing to work would go far. Reference: The Montgomery County Medical Society, Dayton, Ohio. Contact: Harold M. James, M.D., 704 Huffman Ave., Dayton, Ohio. Phone: 513/252-4531 (Office) or 513/293-2554 (Residence).

THE OHIO STATE Medical Journal

APRIL 1977
Volume 73, Number 4



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STATE MEDICAL ASSOCIATION

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Generic Drug Substitution

Two identical bills, S.B. 45 (Freeman, D-Canton) and H.B. 151 (Orlett, D-Dayton), which propose repeal of Ohio's anti-substitution law, are moving quickly through their respective committees. These bills, promoted by the Ohio Pharmaceutical Association, will remove the current requirement that a pharmacist dispense only specifically prescribed drugs unless given physician permission to substitute. The Ohio AFL-CIO has announced its support for S.B. 45 and H.B. 151 based upon supposed potential consumer savings. The OSMA opposes these bills and encourages members to contact local legislators to express their concern about the problems for the patient this type of legislation can bring.

Informed Consent

House Bill 213 (Murdock, R-Cincinnati), legislation to delete the statutory informed consent form included in the Medical Malpractice Act (H.B. 682), was passed by the House Judiciary Committee after being amended significantly by the House Judiciary Committee. Although the bill was introduced originally to abolish the informed consent form, it also included a provision eliminating any potential hospital liability. This latter provision was amended to establish hospital liability for the acts of physician independent contractors who perform medical or surgical procedures in the hospital. An additional provision requires a written form if used to state who will be performing the surgical procedure. This amendment is in response to a growing question of "ghost surgeons." The bill now goes to the House Rules Committee to be placed on the calendar for consideration before the full House.

Physical Therapy Legislation

House Bill 209 (Rankin, D-Cincinnati), to transfer the regulation of physical therapists from the State Medical Board to a Board of Physical Therapy and to expand the definition of physical therapy, has been referred to a subcommittee of the House Health and Retirement Committee. Rep. Les Brown (D-Columbus), Rep. A. G. Lancione (D-Bellaire), and Rep. Robert Taft II (R-Cincinnati) are members of the subcommittee. The legislation in its present form expands the definition of physical therapy into areas of the practice of medicine. H.B. 209 deletes the statutory requirement of a physician's prescription and referral to a physical therapist. A requirement of physician's referral is contained in the bill through a reference to the Physical Therapy Rules of Ethics, but no language is contained in the bill itself.

Diagnostic Drugs for Optometrists

The Ohio Optometric Association is pushing legislation permitting optometrists to use diagnostic drugs and redefining the practice of optometry. Senate Bill 163 (Jackson, D-Cleveland) will license optometrists to use diagnostic pharmaceutical agents. The bill was referred to the Senate Education and Health Committee, whose chairman is the chief sponsor of the bill. Optometrists throughout the country are campaigning to expand the practice of optometry and to get statutory permission to use diagnostic drugs. Only last year, West Virginia gave optometrists the right to use diagnostic *AND* therapeutic drugs. Optometrists have little training in anatomy or physiology; and while they may be trained to administer diagnostic drugs, they would be unable to medically recognize or treat drug reactions.

Anesthesiologist's Assistants

Senate Bill 130 (Jackson, D-Cleveland), permitting anesthesiologist's assistants to administer anesthetics, received its first hearing before the Senate Education and Health Committee. S.B. 130 is a legislative reaction to the Ohio State Medical Board statement that "there is no statutory authority under Ohio's statutes for anesthesiologist assistants." The OSMA Committee on Health Manpower has reviewed S.B. 130 and has recommended a neutral position on the legislation until a survey on this subject is completed by the Ohio Society of Anesthesiologists.

Geriatric Medicine Offices

House Bill 252 (Begala, D-Kent), requiring the creation of an office of geriatric medicine at state-supported colleges of medicine, has passed its hearing in the Human Resources Committee and now goes to the House Finance Committee for its review of the requested funding. The legislation mandates the inclusion of courses and clinical experience in geriatric medicine at state medical schools. The OSMA supports the concept of this legislation but is watching cautiously to be sure the development of curriculum is kept within the school and not specifically mandated in statute.

Product Liability Legislation

H.B. 319 (Cook, D-Cuyahoga Falls) to clarify the statute of limitations for manufacturers to persons with whom they had no contractual relation is being heard before the Insurance, Utilities, and Financial Institutional Committee. The legislation establishes a *12-year* statute of limitations for manufacturer liability and requires the date of manufacture to be posted on the product. H.B. 343, another products liability bill (Tranter, D-Cincinnati and Baumann, D-Columbus), requires proof of negligence by the manufacturer of the product as a prerequisite to liability. A statute of limitations based on average useful life and time of the sale is also included in the bill.

M.D. Jury Duty Exemption

H.B. 267 (Lehman, D-Cleveland) to amend Ohio's jury duty exemption statute passed the House Judiciary Committee and is going to the House Rules Committee.

the federal scene

(Courtesy the OSMA Department of Federal Legislation)

"The Ohio State Medical Association has no alternative but to express its most strenuous and serious objections to certain provisions in H.R. 3, the Medicare Anti-Fraud and Abuse Amendments of 1977," stated OSMA President George N. Bates, M.D., in reference to joint Congressional hearings on the proposed legislation March 3 and 7. The hearings were conducted by the Health Subcommittee of the House Committee on Ways and Means and the Subcommittee on Health and Environment, Committee on Interstate and Foreign Commerce.

Dr. Bates addressed his statement to Congressman Willis D. Gradison, Jr., (D-1st Ohio District), a member of the Ways and Means subcommittee. The statement was to be included in the official proceedings of the hearings. On behalf of OSMA, Dr. Bates stated:

This Association must express strong concern about Section 1125 and about the PSRO amendments. Section 1125, which defines a "Shared Health Facility," if enacted into law, might well be declared unconstitutional. It also would tend to force physicians to discontinue their professional services for any programs receiving federal funds under titles V, XVIII and XIX of the Social Security Act.

This legislation is an attempted federal invasion into the privileged privacy of the patient-doctor relationship and into the personal medical records of the physician.

This is brought about by the proposed Professional Standards Review Organizations amendments on page 18. The bill provides that a PSRO, which is federally financed, may request from the Secretary of Health, Education and Welfare the responsibility to review the records of physicians in a "shared health facility." The bill further provides that the Secretary shall give priority to such requests, and highest priority in some areas.

The "shared health facility" definition in the bill would include almost all practicing physicians except those in solo practice. This means that the federal government—through the PSRO—could invade a vast majority of physicians' private offices and demand to inspect their Medicare and Medicaid patient medical records and other related records.

Further, the bill does not require any evidence of fraud or abuse nor any other grounds for such invasion. Instead, it attempts to provide what might be unconstitutional search and seizure.

It is ironic that, just as this bad legislation is being considered, the National Bureau of Standards announces that Americans have little privacy remaining as far as their medical records are concerned. And the report of the Bureau's two-year study blames the third-party payment for medical care and the collection of personal information resulting from such payment as the root of the problem.

In commenting on that report, Alfred M. Freedman, M.D., president of the National Commission on Confidentiality of Health Records, states that it is people and not computers that violate these delicate confidences. Dr. Freedman, who is past president of the American Psychiatric Association, said a new national consciousness is needed. He warned, "We all need to be constantly aware of the delicate, complex balances which must be struck between the patient's right to privacy and society's need for legitimate information."

Before going further, I will state clearly and emphatically that:

1. The Ohio State Medical Association is unequivocally and adamantly opposed to any manner of fraud or abuse in any medical relationship or any manner of payment for medical services.
2. The Ohio State Medical Association has repeatedly and publicly gone on record, including direct statements to the Congress of the United States, that it will investigate any written charges of fraud or abuse, or any similar accusation of unethical conduct on the part of a physician member.
3. This Association cooperated willingly and fully with the HEW Medicaid fraud team which investigated Ohio physicians, on both a selected and random basis in 1976.
4. The Ohio State Medical Association does not oppose and does not fear the investigation of any of its members, but such investigation must be on a basis of reasonable evidence. Further, the Association stands ready to exercise its due process discipline or to expel any member found guilty of such fraud or abuse.

Unfortunately, Congress has been led erroneously to believe that the huge cost overruns in Medicare and Medicaid are directly attributable to and limited to two factors: physician fraud and physician fee increases.

The fiscal facts are that grossly under-estimated federal budgets and grossly under-estimated participation and utilization have been consistently presented to the Congress by the Department of Health, Education and Welfare. Add those chronic short-comings to the "services on demand" philosophy of the programs plus the abuses on the part of the Medicare-Medicaid patients and the bottom line becomes the multi-billion-dollar budgets and huge budgetary increases that annually confront the Congress and the various state legislatures.

Consider these facts.

1. Ohio, which pioneered welfare assistance long before Medicaid, had approximately 78,000 on its assistance rolls when Medicaid was enacted. As of January 1, 1977, Ohio had 729,158 eligible Medicaid recipients. **This is an increase of nearly one thousand percent in a decade.**

2. Nationally in 1968, physicians' services accounted for **11.9 percent** of the tax dollar spent for medical care under various public assistance programs. In 1975, that figure had dropped to **10 percent, a 19 percent decrease.**

3. The share for prescription drugs decreased from 6.8 percent to 6.6 percent.

4. There have been more than one hundred indictments in Ohio in 1976-77 for welfare abuse and fraud by persons other than providers of medical and health services.

5. Little, if anything, is being done to curb abuse by persons who are supposed to benefit from these programs. Item: A Medicaid beneficiary in Ohio obtained 225 narcotics prescriptions from three doctors and three hospitals in one year; another obtained 101 narcotics prescriptions from two hospitals in one year. These are just two of many examples.

6. A national television program (Sixty Minutes) showed that Medicaid recipients blatantly and fraudulently loaning their eligibility cards to persons not eligible for Medicaid, yet little has been done about such abuse.

I am constrained to emphasize that fraud and abuses deteriorate the availability of tax dollars so necessary to help those eligible recipients who need help. Those who commit these crimes are, in reality, stealing from the needy inasmuch as Congress and the various state legislatures appropriate tax dollars to aid the needy.

Our opposition to H.R. 3 and its attempted invasion of the private physician's office, his medical records and other records should not be construed as opposition to meaningful physician review of medical services conducted by physicians. Prior to enactment of the PSRO amendments, this Association had introduced in the Congress legislation to provide a highly sophisticated professional review of medical services to Medicaid and Medicare patients. Unfortunately it did not pass. Further, this Association, at considerable expense and thousands of physician hours, developed a highly sophisticated, hospital-based peer review system before there was a PSRO law.

Millions and millions of tax dollars would be expended uselessly and unnecessarily if the definition of a "Shared Health Facility" and the PSRO amendments in H.R. 3 are adopted and fully implemented.

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THE OHIO STATE Medical Journal

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Enjoy Columbus During the Annual Meeting

Compiled Through the Efforts of the Academy of Medicine of Columbus and Franklin County

Columbus is the site of the 1977 OSMA Annual Meeting. It is also the capital of Ohio, the home of Woody Hayes and his Buckeyes, the city of Lazarus and The Union department stores, and the meeting point of the Olentangy and Scioto Rivers. Located in Columbus are the penitentiary, Borden headquarters, the Owls hockey team, and about one million people.

Columbus is more than jobs and roofs to those people. It is places to go . . . to eat, to visit, to shop. With the assistance of the members, Auxiliary, and staff of the Academy of Medicine of Columbus and Franklin County, *The Journal* has compiled a suggested list of what to see and where to eat while in Columbus for the Annual Meeting, May 14-18. The following suggestions are only a partial listing of all that is available in Ohio's capital, and the selections and comments represent the personal opinions of the column collaborators.

The members, auxiliary, and staff of the Academy of Medicine of Columbus and Franklin County urge Annual Meeting participants to get to know Columbus. The city, its activities, and its people are worth the effort.

Visit

Battelle Memorial Institute

Battelle Memorial Institute, established in 1925, is a multinational, public-purpose organization. Its objective is benefit for mankind through technological innovation and educational activities in science. More than 6,000 scientists, engineers, and supporting specialists work at its research centers in the U.S. and Europe. The studies are supported by industry, governmental agencies, and other organizations throughout the Free World. Currently, the Institute's worldwide research volume is in excess of $170 million.

Tours of the Battelle facility, located at 505 King Avenue, are available every weekday. These tours are free and last approximately 1½ hours (no children under age 12 years). Tours begin at 8:30 and 10 AM and 1 and 2:30 PM. For further information, contact Ms. Marty Buller, 424-7824. Reservations for groups are suggested.

Center of Science and Industry

The Center of Science and Industry (COSI) of the Franklin County Historical Society essentially houses four museums: **Sciences** emphasizes space and earth sciences; **Health** covers such topics as birth, parts of the body, and drug education; **Industry** includes such exhibits as "The Story of Electricity" and "The Story of Paint"; and **History** has an exhibit from the New York World's Fair and a Hall of U.S. Presidents.

In addition, the Durell Street of Yesteryear may be found in the History section. This street depicts Columbus' Main Street in periods beginning in 1840 and extending to 1910. The visitor will find various trade shops and entertainment centers, some of which operate.

Other highlights of a trip to COSI are the planetarium featuring seasonal shows and the Foucault pendulum.

COSI is open 10 AM - 5 PM Monday through Saturday, 1 - 5 PM Sunday. There is a nominal admission fee.

Gallery of Fine Arts

Six exhibitions will be on display in the Columbus Gallery of Fine Arts, 480 East Broad Street. Visitors may view a major portion of the museum's permanent collection, the **Frederick W. Schumacher Collection,** in the West Galleries. A strikingly arranged exhibition, the Schumacher consists of many fine examples of painting, sculpture, and drawings.

Downtown Perspectives, a multi-media exhibition of present and potential downtown Columbus, will fill the Media Gallery. This popular exhibit consists of a 10-foot-square, three-dimensional model of downtown Columbus; black-and-white, "blow-up" photographs; and a continuous slide show with accompanying sound track.

A richly varied collection of **textile and metal art works** is scheduled for the Packard Gallery. Harriett Anderson's work will be represented by wall-hangings, pillows, and the like. Kent Vander Plas, an artist/craftsman working in metals, is particularly noted for his pewter works, a number of which are included in the exhibit. This collection will remain through May 15.

The East Galleries will feature a major **photography** exhibition. Masters of the Camera, a retrospective of outstanding 20th Century American photographers, includes the work of such masters as Stieglitz, Steichen, Lange, and Haas.

The **67th Annual Columbus Art League May Show** will be in progress in the New Wing. Made up of selected works by central Ohio artists, the event is extraordinarily varied in content and style.

Opening May 14 in the Sessions Gallery will be **Lilliput, U.S.A.**: American miniature furnishings, 1830-1930. Made up of 20 cases of miniature furniture in appropriate settings, the collection is not only charming but also provides insight into the popular furniture styles of the various periods.

(continued on page 192)

Enjoy Columbus *(continued)*

The Columbus Gallery of Fine Arts is open 11 AM - 5 PM Tuesday, Thursday, Friday, and Sunday; 11 AM - 8:30 PM Wednesday; 10 AM - 5 PM Saturday; closed Monday. There is a nominal admission charge except on Tuesday, when admission is free. For more information call Rosemary Hite, 221-6801.

Ohio Village

The Ohio Historical Center, located on 17th Avenue just west of Interstate 71, offers many interesting displays including the Ohio Village. Patterned after such reconstructed towns as Williamsburg, Virginia, and Sturbridge Village, Massachusetts, the Village is Ohio circa 1850. Buildings include shops of craftsmen, a hotel, and a physician's office. Skilled workmen ply their trades as visitors watch and later purchase the products.

Karen S. Edwards, editor of *The Bulletin* of the Academy of Medicine of Columbus and Franklin County, wrote of the Village in "A Stroll Back Through Time." In the June 1975 *Bulletin* article, she said:

> If the streets are a little muddy, there are boardwalks encircling the town, but no concrete drive or walk-way to make the going any cleaner.
>
> If the weather decides to turn hot, then pray for a breeze, because air conditioning was not in existence in 1850, and it's not in existence here.
>
> And don't expect to go to the Hotel to cool off with a soft-drink. You might ask for a glass of cider or lemonade, but the fizzy, carbonated drinks belong to a later era.
>
> Despite these trivial discomforts, however, the Ohio Village offers a first-rate education in "living" history.

The Village is open 9 AM - 5 PM Wednesday through Sunday. There is a nominal admission charge.

Zoo

The Columbus Zoo, located on the northwest side of the city along the Scioto River, is a wonderful spot for child and adult. The view of the river and yacht club opposite is worth the trip, but the animals provide added fun.

The Columbus Zoo, celebrating its 50th Anniversary in 1977, boasts the only three generations of apes in the world. Colo, born December 1966, is the first captive-bred gorilla in the world. Emmy, Colo's daughter, is the first second-generation gorilla born in captivity. Colo has followed Emmy with two more young.

The late reptile curator, Lou Pistoia, developed and maintained the largest reptile collection in North America, of which at least a dozen snakes hold longevity records. In 1973, Mr. Pistoia and the Columbus Zoo won the Bean Award of the American Association of Zoological Parks and Aquariums for breeding and raising Jamaican boas.

In addition, the Zoo has one of the few pairs of mating American bald eagles in captivity. Also, a pair of white rhinos, currently on the endangered species list, are housed in the pachyderm building.

Youngsters will enjoy the Children's Zoo, featuring a waterfront partyhouse, outdoor stage for animal demonstrations, and a barnyard petting zoo. They also will have great fun riding the Scioto Belle Riverboat and the Zepher Tour Train.

The Zoo is open from 10 AM to 5 PM everyday. There is a nominal admission charge that is reduced on Thursdays. For further information contact Debi Scheerer, 889-2596.

Shop

Colony Bazaar

Located on the northeast corner of Kenny and Henderson Roads. Enclosed shops, all under one roof. Some fast food shops within, one specializing in crepes. Next door to T.G.I. Friday's, a New York antique bar and restaurant.

The Continent and French Market

Located at 6172 Busch Boulevard, just off Route 161. Over 30 unique shops and restaurants, most specializing in foods, under the French Market roof. Equally as many shops along the avenues of The Continent, including men and women's apparel, items for the home, jewelry, and cinemas.

German Village

Located in south Columbus just below intersection of High Street and Interstate 70. A variety of shops and eating places in this restored historic section. Spots of interest include The Marianplatz, 631 South Third Street — shops feature china, candles, stained glass, and antique and turquoise jewelry; The Old World Bazaar, 555 City Park Street— shops in an old streetcar barn. Take time to wander throughout this area.

Worthington Square

Located on North High Street just south of Interstate 270 in Worthington. Over 30 shops offering apparel for men and women, jewelry, turquoise, leather, and Oriental specialties. Also cafeteria and cinemas.

Eat

Bonapart's Dining Room (Carrousel Inn)
Sinclair at Interstate 71. 846-0300.
Good food. Interesting atmosphere with tables surrounding twin grand pianos. Music excellent. Average dinner $10. Entertainment in the lounge. Reservations suggested.

Brown Derby
1321 Morse Road. 261-0243.

(continued on page 194)

When impotence due to androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement, +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** **Robert B. Greenblatt, M.D.**, and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

Enjoy Columbus *(continued)*

Acceptable food, large room with plants and stained-glass windows, adequate service. Average dinner $4-$8. No particular specialties. Rock band evenings.

Bryn Mawr
Route 37, Granville. 587-4000.
About 45 minutes from downtown Columbus. Very good food. Charming turn-of-the-century decor. Very good service. Average dinner $8-$12. Specialties: the mushrooms before, the caramel custard afterwards. Great and inexpensive Sunday brunch. Piano player lower level evenings. Reservations suggested.

Burgermeister's Wein Haus
961 South High. 443-7200.
Excellent German food. Authentic with accompanying German wine imported by the owner who has vineyards in Germany. Average $6-$8 per meal.

Candlelight Dining Room (Neil House)
41 South High. 221-5221.
Probably "the undiscovered restaurant" in Columbus. Food is very good and the Sunday brunch is so good and inexpensive as to be unbelievable. Nightly entertainment. Charming Fifties decor. Very good service. About $8 for evening meal.

Casa di Pasta
2321 North High Street. 294-9784.
No better Italian food in the city. Charming front room with back room somewhat larger. Operatic singers on the weekend. Good service. Average dinner $4-$8. Specialties: Bracciolo (rolled steak) and Cannoli (pasta dessert). Reservations suggested.

Clairmont Steak House
684 South High Street. 443-1125.
Excellent steak. Adequate decor, excellent service. Average dinner $8. Reservations suggested.

Clyde's
499 South High Street. 224-7411.
Good food, good decor. Specializes in steaks and crepes. Average dinner $8. Jazz piano weekends. Reservations suggested.

Engine House #5
121 Thurman Avenue. 443-4877.
First-class decor. Very good-to-excellent sea food. Adequate service. Price range about $6-$10. Entertainment downstairs nightly.

Fisherman's Wharf
1048 Morse Road. 436-4633.
Good seafood. Specialty is the bouillabaise. Also Greek dishes—try the Greek salad. Good service. Average dinner $8-$10. Reservations suggested.

Henry's (Christopher Inn)
300 East Broad. 228-3541.
Continental menu with American entrees as well. Good service. Good food. Average meal about $10. Excellent entertainment in the Poolside Room.

Inner Circle
16 West Beck Street. 221-8953.
A "gourmet restaurant." Acceptable to good food. Excellent rooms. Fair service. Average dinner $8-$12. Entertainment in "The Great Escape." Reservations suggested.

Jai Lai
1421 Olentangy River Road. 421-7337.
An old Columbus standby with meals between $6-$10. Adequate food though some say it's the best restaurant in town. Room is large. Service good. Reservations suggested.

Japanese Steak House
270 East Town Street. 228-3030.
Usual Japanese steak house with meals averaging $8-$12. You may eat with other people at same table unless you have a full table of eight. Service good. Room has usual Japanese/American decor. Reservations suggested.

L'Armagnac
121 South Sixth Street. 221-4046.
Excellent and inexpensive wine list. Excellent service. Excellent food and decor. Can't go wrong here. Average dinner $12-$15. Reservations suggested.

Olde Church House
1092 Bethel Road. 451-9774.
Good drive from downtown, but probably worth it. Continental food of good-to-very good quality. Good service. About $10-$12 per meal. Reservations suggested.

Oliver's Tavern (Stouffer's University Inn)
3021 Olentangy River Road. 267-0355.
Steaks and chops. Adequate English decor. Average price $6-$8. Piano player weekends. Reservations suggested.

Place Upstairs
595½ South Third Street. 228-8861.
One of the best of German Village restaurants with excellent prime steak. Reasonable prices, $6-$8 per meal. Very good decor, particularly the front room. Reservations suggested.

Peacock China Room
5617 North High Street. 888-2525.
3991 East Broad Street. 237-7141.
Specializes in Mandarin and Szechwan dishes, as well as Cantonese. Unusually varied selection of Chinese

dishes plus steaks and chops. Chef's choice: Hundred-Blossom Lang, Lemon Chicken, or House Chow Mein.

Planks Garden
888 South High Street. 443-4570.

Tiffany's
821 Mohawk. 444-7204.
Good German restaurant in German Village. Average meal $6. Decor varies little. Service good.

Schmidt's Sausage Haus
240 East Kossuth. 444-6808.
Fun German restaurant featuring bratwurst and "Bahama mamas." Delicious desserts. Candy shop makes fudge while customers watch. German band evenings.

Top of the Center
100 East Broad Street. 221-5555.
Steak-and-chop American menu. Food acceptable-to-good. Average meal $10-$12. View Columbus from above. Entertainment nightly. Reservations suggested.

Waterworks
225 North Front Street. 224-2444.
Decor is better than food, but food is acceptable. Recent first-run movies on Friday and Sunday. Average dinner $8. An offbeat, enjoyable place.

Wine Cellar
1777 East Dublin Granville Road. 885-0017.
Good food. Excellent decor with hanging plants. Average meal $10-$12. Often crowded. Will not take reservations. Entertainment nightly.

Be Entertained

Country Dinner Playhouse (11500 Tussing Road, Reynoldsburg. 864-1760.)

"The Bread-and-Butter Man"
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Drake Union Theatre (Ohio State University Campus. 422-2295.)

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By Anton Chekov

Mershon Auditorium. (Ohio State University Campus. 422-2354.)

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Address _____

City _____ State _____ Zip _____

The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

Periodic Programs

ANESTHESIA DEPARTMENT MEETING: 2nd Thursday, each month, 7:30 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Theodore Stoner, M.D., 2306 Park Avenue, Cincinnati 45206, phone: 513/221-1594.

BASIC NEUROSCIENCES: Every Thursday, 7:30 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Frank Mayfield, M.D., Neurosurgery Section/Surgery Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2533.

CARDIO-THORACIC CONFERENCE: 2nd and 4th Friday, each month; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: J. R. Zerhusen, M.D. or Georges Daoud, M.D., c/o Cardiac Lab, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2683.

FAMILY PRACTICE DEPARTMENT MEETING: 1st Thursday each month, 11 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Richard Lamping, M.D., 209 West Benson Street, Cincinnati 45214, phone: 513/821-2346.

GASTROINTESTINAL GRAND ROUNDS: 2nd Wednesday, each month, 10:45 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Thomas Saladin, M.D., c/o Medical Education, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, pohne: 513/872-2421.

INTERNAL MEDICINE DEPARTMENT MEETING: 2nd Thursday, each month, 11 AM; Good Samaritan Hospital; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour: contact: Thomas Saladin, M.D., c/o Medical Education Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

INTERNAL MEDICINE GRAND ROUNDS: Every Wednesday, 9 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Thomas Saladin, M.D., c/o Medical Education, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

NEUROLOGY CONFERENCE: Every Thursday, 8:30 AM; Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education Office, Good Samaritan Hospital; 1 credit hour; contact: Frank Mayfield, M.D., Neurosurgery Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2533.

OB/GYN GRAND ROUNDS: 3rd Wednesday, each month, 8 AM; Cincinnati Hospitals (rotation basis); sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour: contact: Fawzy Mansour, M.D., c/o Medical Education, Good Samaritan Hospital, 2317 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

III SURGICAL SERVICE MEETING (with Frank Ellis, M.D.): Every Tuesday, 5 PM; Good Samaritan Hospital, Cincinnati: sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Frank Ellis, M.D., 3308 Jefferson Avenue, Cincinnati 45220, phone: 513/281-2032.

UROLOGY GRAND ROUNDS: Every Saturday, 7:15 AM; Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: H. Willis Ratledge, M.D., 4966 Glenway Avenue, Cincinnati, 45238, phone: 513/872-2421 or 921/1443.

Single Course Offerings

April 1977

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: April 19, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DERMATOLOGY CONFERENCE: April 19, 8:30 AM; Riverside Methodist Hospital: 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

OHIO VALLEY CONFERENCE ON SPORTS MEDICINE: Sunday, April 24; 12 noon; Steubenville Country Club, Steubenville; sponsors: Ft. Steuben Medical Foundation, Ohio Academy of Family Physicians, Joint Advisory Committee on Sports Medicine — OSMA and Ohio High School Athletic Association: 4 credit hours; fee: $10 physicians (coaches, trainers, school administrators admitted free); contact: Sanford Press, M.D., 525 N. Fourth Street, Steubenville 43952, phone: 614/282-4893.

DEPARTMENTAL GRAND ROUNDS AND CONFERENCES: April 26, 7:30 AM; Riverside Methodist Hospital, Columbus; sponsor: Riverside Methodist Hospital; 1 credit hour; contact: Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

MORBID OBESITY WITH INTESTINAL BYPASS: April 26, 8:30 AM; Riverside Methodist Hospital; 1 credit hour; contact Medical Education Office, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CARE OF MENTALLY RETARDED IN MARION COUNTY: (Jerry Manuel, Superintendent, Marca Schools, speaker); April 28; Community Medcenter Hospital, Marion;

sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

THE DISABLED PHYSICIAN AND HIS FAMILY: April 29-May 1; Kings Island Inn, Mason; sponsor: Ohio Academy of Family Physicians; 8 credit hours; fee $40 (AAFP member); $65 (non-member); $30 (FP resident); contact: Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214. phone: 614/267-7867.

May 1977

NEW DIRECTIONS IN TRAUMA: May 5-7; Holiday Inn of Toledo- Perrysburg, Toledo; sponsor: Department of Surgery, Medical College of Ohio and American Trauma Society; 15 credit hours; fee: $100; contact: Howard S. Madigan, M.D., Medical College of Ohio, C.S. 10008, Toledo, Ohio 43699, phone: 419/381-4237.

CONTINUING EDUCATION PROGRAM IN NUCLEAR MEDICINE FOR PHYSICIANS: May 9-13; July 11-15; November 14-18; Hillcrest Hospital/Nuclear Medicine Institute, Cleveland; sponsor: Nuclear Medicine Institute; cosponsor: Hillcrest Hospital; 40 credit hours; fee: $100; total tuition including registration fee: $500 ($200 residents); contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

SELECTION OF MEDICAL STUDENTS AND CURRENT ASSESSMENT OF THEIR PROFICIENCY: (J. Hutchison Williams, M.D., speaker); May 12: Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

1977 CLINICAL NUTRITION UPDATE SYMPOSIUM: May 16-17; Akron City Hospital, Akron; sponsor: Akron City Hospital; 13 credit hours; contact: Linda Kerlee, Medical Staff Secy., Akron City Hospital, 525 East Market St., Akron 44309, phone: 216/375-3000.

June 1977

DOCTORS' GRAND ROUNDS: June 9; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Mr. Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

CURRENT MANAGEMENT OF OCULAR EXTERNAL AND INFECTIOUS DISEASE: June 9-10; Bunts Auditorium, Cleveland Clinic Educational Foundation; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $150 ($50-residents); contact: Penn G. Skillern, M.D., Center for Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

MICRONEUROSURGERY SYMPOSIUM: June 9-11; Cincinnati Convention Center; sponsor: Departments of Neurosurgery, Christ and Good Samaritan Hospitals; 25 credit hours; fee: $250 physicians, $150 residents (when accompanied by an endorsement from program director) and nurses; contact Stewart B. Dunsker, M.D., or John Tew, Jr., M.D., 506 Oak Street, Cincinnati 45219.

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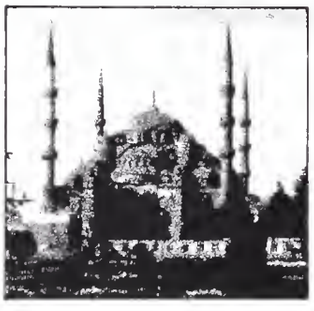
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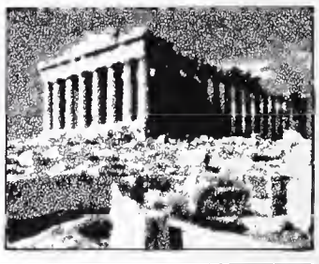


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Financing a medical education today can be a serious problem. With costs rising at almost every turn, it is a rare individual or family who can afford to shoulder the full burden. Government and foundation loans for medical education have become scarcer, and the competition for funds that are available has become keener because more students are entering medical school than ever before.

The American Medical Association-Education and Research Foundation (AMA-ERF) has established a program to help eliminate the financial barrier to medicine for all who are qualified and are accepted by an approved training institution. The purpose of AMA-ERF is (1) to raise funds for medical education that are given to medical schools as unrestricted funds; (2) to provide guaranteed loans for medical students, interns, and residents.

Unrestricted grants are important to medical schools because medical schools are always in need of flexible financial aid. They need millions of additional dollars. AMA-ERF funds are given with no strings attached and, thus, can be used to solve the most pressing financial problems. Contributors may designate their checks for the medical school of their choice; or they may donate to the general fund for medical schools, these monies being divided equally among all accredited schools at the end of the calendar year.

The Student Loan Guarantee Program is the result of a cooperative effort by American medicine and private enterprise. Loans are issued by various commercial banks directly to students, interns, and residents. For every dollar the AMA-ERF deposits in a cooperating bank, the bank loans $12.50 to students. AMA-ERF guarantees the loans which are made to students recommended by the deans of the respective medical schools.

From 1962, when the program began, until September 1, 1976, AMA-ERF has guaranteed and the participating banks have made loans totaling $70 million for medical students, interns, and residents. The Foundation has distributed gifts of more than $27 million in unrestricted grants directly to the nation's medical schools. In addition, AMA-ERF has provided substantial funds for categorical research grants, scholarships, and programs to improve the quality and availability of medical care in under-serviced areas.

As physicians' spouses, Auxiliary members are interested in the profession. Working for AMA-ERF is one of the ways the Auxiliary can provide better medical education.

Most county auxiliaries have at least one fund-raising project each year. As an example, last year Clark County had a holiday auction of member-made items. The AMA-ERF contribution from this one activity was $759.

Many Ohio county auxiliaries now raise large sums of money with their own auxiliary Christmas card. This card reaches every member of the county medical society; hence, all the physicians and their spouses become acquainted with the program. The sales pitch for the card is providing funds for AMA-ERF through sending the "Sharing Card" to wish all a Happy Christmas. Large counties realize thousands of dollars, smaller ones hundreds, from this project. Montgomery County netted $4,500 last year with a card designed by one of their own members, Mrs. Sylvan Weinberg.

Last year, Ohio's auxilians and their spouses contributed a total of $66,179.81 to AMA-ERF. The majority of this amount was divided among the six Ohio medical schools in the form of unrestricted funds: Case Western Reserve, $11,226.76; Medical College of Ohio at Toledo, $4,067.14; Northeastern Ohio Universities College of Medicine, $3,581.84; Ohio State University College of Medicine, $14,668.23; University of Cincinnati College of Medicine, $16,680.86; and Wright State University School of Medicine, $4,365.88.

AMA-ERF is literally "rolling along" in Ohio this year. Beginning in September in Circleville, AMA-ERF State Chairman Mrs. Kenneth Harshman and Auxiliary Treasurer Mrs. John Liambeis visited Lucas, Tuscarawas, Jefferson, Montgomery, Delaware, Ashtabula, Cuyahoga, and Lake County Auxiliaries. They displayed a "traveling boutique," which contains jewelry, scarves, handbags, and other lovely items that are sold to benefit AMA-ERF.

As a result of all these efforts, Ohio was #1 in the nation in contributions to AMA-ERF at the end of the first 1976-1977 reporting period. As of January 15, 1977, Ohio auxiliaries have contributed $30,644.43 to AMA-ERF.

All OSMA members are encouraged to contribute to the 1977 campaign. Contact your local auxiliary, county medical society, or the OSMA. Please do so today to support quality medical education.

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LEFT: John H. Budd, M.D., Cleveland family physician, and his wife, Irma. ABOVE: Left to right at an OSMA Council Meeting— C. Edward Pichette, M.D., Sixth District Councilor; P. John Robechek, M.D., Chairman, Ohio Delegation to the AMA; Stephen P. Hogg, M.D., First District Councilor; Dr. Budd; W. J. Lewis, M.D., Second District Councilor and candidate for AMA Vice Speaker; and James E. Pohlman, Esq., OSMA Legal Counsel.





LEFT: Dr. Budd, AMA President-Elect, is seated on the dais at the 1976 AMA Clinical Convention. ABOVE: George N. Bates, M.D., OSMA President (left), joins Dr. Budd at a reception given in his honor by the Cleveland Academy of Medicine.

AMA President

AMA Annual Meeting, June 18-22, San Francisco



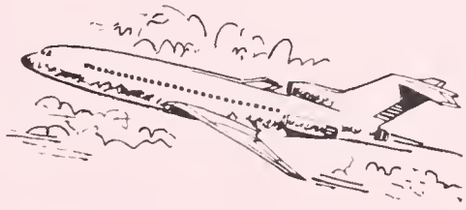


ABOVE: Dr. Budd is equally as skilled a musician as he is a spokesman for medicine, and he often joins a jazz group.



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Solo Practice With Scheduled Rest and Relaxation

Harry Cameron Mack, M.D.

How does 20 days' scheduled vacation and alternate weekends off with full coverage of practice appeal to you "go-it-alone" practitioners? Four Toledo internists have these benefits and like them. (So do their wives!)

By reason of temperament, location, and habit, many physicians will continue in the solo practice of medicine. We all are aware of real advantages and disadvantages of this mode of practice for ourselves and for our patients. Yet, with the increasing workload, the solo practitioner especially has felt a compelling need for time off for vacations, time with his family, meetings, organizational responsibilities, and just a respite from the pressure of the many telephone calls and from being "on call" constantly. Each of us in this new coverage system had haphazard arrangements in the past — best described as "hit and miss," often not 100 percent satisfactory, and without equal reciprocation. To remedy some of the faults with our previous coverage, four of us met in February of 1973 and worked out a scheduled-coverage and time-off arrangement that has proved mutually satisfactory to each of us, to our wives and families, and to our office girls Friday. Our success probably relates to all of us having established practices, all practicing the same type or intensity of internal medicine, and all having felt the pressures building for well-deserved rest and relaxation.

Having established practices with a load volume with which we all could live has helped our system work. Obviously, if one of our participants had been new in the city or in practice and was attempting to build a clientele at the expense of his covering partners, this would lead to a rapid deterioration of any system. By refusing to take on patients of participating physicians, or to see them when their own physician is in town or on call, potential sore points have been averted. All records for patients seen while covering, including hospital case summaries, office- and house-call notations, and telephone advice are sent to the physician on his return from vacation and after weekends off. Forwarding all coverage records and informing patients when they call that this has been done discourages "doctor hopping." When information for insurance forms and other data are requested later, direct calls to the covering partner's office usually will refresh our memory as to diagnosis, days of care, and charges.

Dr. Mack is in private practice in Toledo.
Submitted October 7, 1976.

Reasons for the Success of This System

Having similar types of practice has helped in the success of our coverage system. With adequate and flexible office hours to allow squeezing in a few patients, an average hospital census of 8 to 12 patients, being available for nursing home and house calls when necessary, patients have access to their accustomed medical care in the absence of their own physician. It is doubtful if such a coverage system would work if one member of the group was totally hospital based, another office oriented, and a third serving only in a consulting capacity. Trying to accommodate another physician's dissimilar practice demands could stretch individual and office personnel flexibility beyond reasonable comfort. Hospital clinics, teaching, and committee work never have been a part of our coverage responsibility.

Loyalty to both the coverage system and the schedule is essential. The demands on our time are severe from practices, hospital affiliations, and professional organizations. In honesty, an occasional hospital or other medical association obligation has been neglected because of the benefits of our coverage arrangement. Any system would fail if "this hospital," "that meeting," or "these social obligations" would take precedence or disrupt the equity in coverage over some other obligation. Further, loyalty demands that professional friends not be allowed to "freeload" on the system. However, other coverage and accommodations are tolerated as long as they don't involve or obligate other physicians in the system.

Our mutual coverage is for time off only. How and where it is spent is of no concern. Continuing education, religious obligations, and professional organization responsibilities vary so widely that attempting to incorporate them in the plan would only complicate and disrupt it as well as produce inequities. The only exceptions are personal and family illness. All of us are flexible enough to accommodate a "bout of 24-hour flu" or an urgent trip out of the city because of an illness or a death.

The coverage system is made up for a year in advance, but plans and obligations can change. When vacation dates are not known beforehand, they can be incorporated into the schedule when they are determined. All of us are willing to, and do, switch "on-and-off" weekends occasionally. This is left to the individual physicians to arrange and compensate, assuming the others know of the changes. Modifications are mailed to each of us to correct our schedule. I keep a copy of the schedule at home and ask my wife to keep it in mind when arranging social and family functions. (Frankly, I don't think she has figured it out yet.)

Coverage doesn't demand sitting home next to the phone — only keeping in touch with our office or answering service. We inform the answering service as to who is on and off call each weekend and ask that they rotate calls between the "on men." When another physician's patient has seen one of us before, particularly for a similar problem, they might request "so and so" again. Generally, however, the work load for the two covering men about equals out. To equalize the duties, we divide our in-hospital patients among the covering men. I have never given in-hospital patients a choice of a covering physician. I feel it is my prerogative to arrange for time off and coverage and, therefore, not a point for debate and discussion between patients and myself.

Scheduling

The wife of one of our partners makes out the schedule each year; she likes to do it. This person is "heaven sent." She relieves us of a very tedious task (like paperwork). When two of us wanted the same vacation time, modifying arrangements usually resolved the conflict. Our heaven-sent schedule always has, and rightly so, put time-off requests on a first-come-first-served basis.

In my office waiting room, I have a sign stating: "Doctor is associated with three other internists for mutual coverage on certain weekends and vacation periods. Please call the office for emergencies after hours or on weekends and, if doctor is not available, doctor's secretary or the answering service (Academy of Medicine) will direct you to the doctor on call."

This must work in educating patients to our coverage system because, in three years, I have not had a complaint about a covering physician. Deep down, the patients all want their own doctor but, at the same time, they recognize our need for rest and time off. Assurance of comparable care seems to allay much anxiety. At least openly, no one has expressed feelings of abandonment when we occasionally leave desperately sick and dying patients and their families under the care of another covering partner.

Financial Arrangements

The financial arrangement between our participants varies, but it assures compensation for work done. We agreed that in-hospital patients, seen over weekends, would be billed by their respective physicians as if seen each day and that the covering physician would render no charges. Over a year's time, with about equal hospital censuses, the monies involved average out and, frankly, one or two hospital visits do not warrant the time and expense of billing, completing insurance forms, and other paperwork. When a new patient is hospitalized and a history and physical examination recorded, either on weekends or while covering partners are on vacation, the covering physician renders his usual charge and bills for them. Patients seen for several days while a partner is on vacation, as well as patients seen in the emergency room, at nursing homes, or on house calls are billed by the covering physician. In our office, we request that visits be "cash calls" to avoid adding these patients to our billing system, which is costly, and to avoid the expense of mailing bills. Most patients are pleased to have readily available care, and they do not resent this. Fees charged by each of us are about equal for services rendered. This adds another element of continuity to patient care.

The four of us meet as required and discuss schedule changes and conflicts, problems, and further plans. Although one might envision a lengthy list of potential problems, few have arisen and, frankly, we don't anticipate many. When a patient complained occasionally about a charge, I always backed the covering man because, in each case, the fee was equal to or only a little more than I would have charged for comparable service. Admittedly, I wouldn't pursue a nonpayment problem as far with another physician's patient as with one of my own. The time and grief involved don't justify the effort and, frankly, the occasions are very few and far between.

Although I have not verified it, I would assume that medical liability in the coverage system is the same as for our own practices. I, for one, didn't modify my malpractice insurance when our plan was started.

Conclusion

Thinking back over the last three years, I believe our coverage system has worked well because our practices are basically similar. We are all dedicated to health care delivery and are firmly established in private practice. Our practices are designed to accommodate patients and their needs — not teaching or research responsibilities. We all have adequate and appropriate office hours, render in-hospital services, and are available for nursing home and home care when needed. We each have learned to adapt to each other's system of care; we don't blindly pursue our way when it conflicts with another's mode of operation. For example, one of our group is much more aggressive with the use of anticoagulants than another. Certainly there is room for both points of view, and a little give and take in this area among ourselves prevents marked discrepancies in care while covering for another. I also have found that under-covering just a bit helps. By this, I mean not trying to become someone's complete physician and attend to every detail when only covering for one or two days. Long-range plans, other medical problems not requiring immediate investigation or concern, and matters discussed but not handled are referred back to the attending physician.

The main thing I have learned about a coverage system is that being off isn't as important as *knowing* you can be off. I suppose it is somewhat like being in jail — knowing you can get away doesn't mean you will take every advantage of doing so. None of us takes full advantage of time off, but knowing it's there if we want it makes the daily care and work of our practice more enjoyable. Finally, the old hassle about leaving town and trying to get coverage just does not exist anymore. My wife and I can plan vacations almost any time, knowing that the "home fires" will be tended in our absence.

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Obituaries

WILLIAM LEROY BRYANT, M.D., Perrysburg; University of Michigan Medical School, Ann Arbor, Michigan, 1939; age 62; died February 10; member OSMA and AMA.

STANFORD S. DAW, M.D., Zanesville; Ohio State University College of Medicine, 1932; age 69; died January 1; member OSMA and AMA.

EDWARD L. DULLE, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1928; age 78; died January 12; member OSMA and AMA.

BYRON GILLESPIE, M.D., Woodsfield; University of Cincinnati College of Medicine, 1928; age 74; died February 10; member OSMA and AMA.

LEROY J. HYMAN, M.D., Gates Mills; New York University School of Medicine, New York, 1941; age 60; died January 30; member OSMA and AMA.

CHARLES LA ROCCO, M.D., Hot Springs, Arkansas; Cleveland-Pulte Medical College, 1912; age 88; died February 2; member OSMA and AMA.

EDMUND PUTERBAUGH, M.D., Tipp City; Ohio State University College of Medicine, 1929; age 76; died February 12; member OSMA and AMA.

ABDUR REHMAN, M.D., Cincinnati; King Edward Medical College, Lahore, West Pakistan, 1967; age 33; died February 1; member OSMA and AMA.

BURDETT SHREFFLER, M.D., Mansfield; Ohio State University College of Medicine, 1924; age 80; died February 10; member OSMA and AMA.

WILLIAM BROWN SMITH, M.D., Zanesville; Ohio State University College of Medicine, 1945; age 57; died January 27; member OSMA and AMA.

BORIVOJ VYROUBAL, M.D., Cleveland; Medicinski Fakultet Sveucilista u Zagrebu, Zagreb, Yugoslavia, 1926; age 74; died October 9, 1974; member OSMA and AMA.

THEODORE WENNING, M.D., Cincinnati; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1910; age 92; died February 14; member OSMA and AMA.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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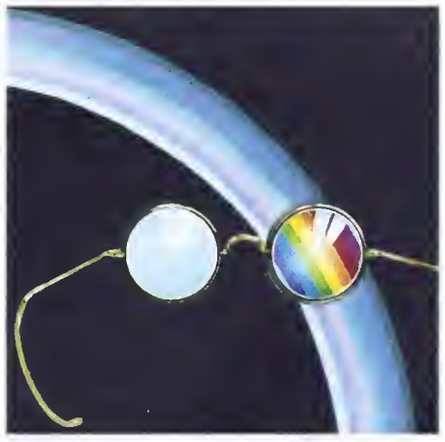
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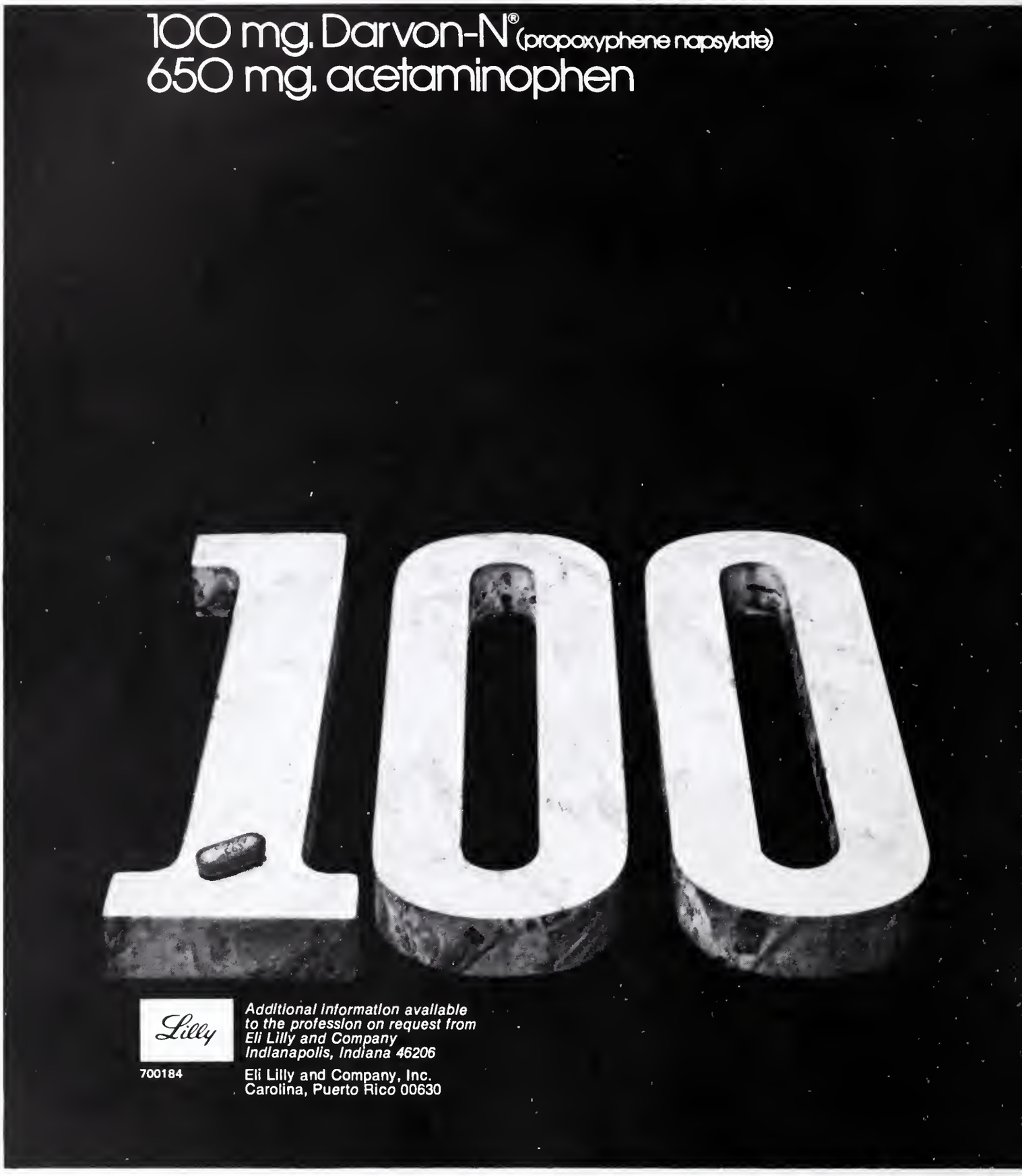
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THE OHIO STATE Medical Association Clinical and Scientific

Noniatrogenic Retrolental Fibroplasia

Joseph A. Masaryk, M.D.
Donald McIntyre, Ph.D.

The changes induced in surgically removed bovine vitreous [corpus vitreum of the eye] specimens by lowering the pH of the fluid surrounding them in vitro were observed both visually and by light-scattering measurements. The turbidities found in the in vitro specimens are discussed in the light of the oxygen transport mechanism in the premature infant which can cause an acidosis for the development of cicatricial retrolental fibroplasia. Laboratory attempts to induce in vivo retrolental fibroplasia in adult dogs by injecting acid into the infraorbital artery of the dog were unsuccessful.

Editor's Note: *The material presented in this article is of considerable interest to any physician involved in obstetrics and the problem of oxygen want in the newborn. The medicolegal aspects are better defined for dealing with the administration of oxygen as a therapeutic agent for the newborn.—R.L.M.*

AROUND 1952, it was concluded that retrolental fibroplasia (RLF) was a mainly iatrogenic disease caused by excessive oxygen administration.[1] In 1964, thick, avascular, fibroplastic proliferation was produced by injecting lactic and acetic acids into the vitreous of kittens.[2]

Oxygen transport in the premature newborn is altered by fetal hemoglobin and respiratory distress. This can produce tissue hypoxia and a severe metabolic and respiratory acidosis. The acidosis can explain the causal relation of oxygen to retrolental fibroplasia (RLF). The eye is a target organ in the newborn whose blood and cardiopulmonary physiology may be radically different at that point in time. The vitreous is a dilute equilibrium gel whose structure and dimensions are due to the highly organized state of the residual collagen. The physical state of the vitreous gel may be altered by decreasing the equilibrium pH.

The pH-induced physical changes of in vitro, bovine vitreous samples were observed by photography and light-scattering measurements. An attempt was made to observe similar changes in vivo with dogs.

Methods and Results

In Vivo. — Healthy, adult, mongrel dogs were used to determine the effect of pH changes on the retinal circulation of animals with normal blood buffers and respiratory function. The dogs were anesthetized with intravenous Brevital® and intratracheal nitrous oxide and oxygen. The infraorbital artery of the dog was isolated and a polyethylene catheter was advanced for approximately 6 cm. Then, 0.5 ml of 10-percent fluorescein was infused, and the fundus vessels were filled in ten seconds. A dilute solution of acetic acid (pH 6) was injected slowly, at the rate of 0.2 cc per minute, until a total of 75 cc was injected. The fundus vasculature and vitreous were observed with an indirect ophthalmoscope through a dilated pupil every 24 hours for 96 hours. No demonstrable change occurred in the retinal vasculature or vitreous. Repeating this process with injections of dilute solutions of acetic acid of pH 5.5, 4.5, and 3.5 did not produce changes in the vitreous or retinal vasculature.

In Vitro. — Bovine eyes were used in vitro. The cornea was incised at the limbus with a razor-blade knife and was totally excised with Castroviejo scissors. The iris was removed completely. The lens was frozen with a liquid-nitrogen cryoprobe and the lens and vitreous removed together. The vitreous was separated into a glass receptacle by brushing the posterior surface of the lens with a sable brush.

Each of the surgically removed vitreous samples was placed in a buffered solution of 0.9-percent saline solution over a period of 96 hours. One sample was kept at a pH of 7.4 to maintain its original pH. Two other samples were kept under acidic conditions of pH 6.8 and 6.0. Visual observation showed that there was a distinct gel phase at all times although its consistency changed with the pH. The sample at pH 7.4 was clear at all times. The sample of pH 6.8 had a slight turbidity, and the

sample at pH 6.0 had a distinct turbidity and contraction. The Figure shows the vitreous at the different pH levels.

Visual and photographic examination of the turbidity also was confirmed by light-scattering measurements with a low-angle, light-scattering photometer using standard light-scattering techniques.[3] The depolarization ratio ([p] the ratio of horizontally-to-vertically polarized light) and the normalized turbidities ([t] normalized to the scattering of the fresh vitreous) were measured at 90 degrees to the incident beam and 546-nm wavelength light. (See the Table.) The turbidities correlate well with the visual observations. However, there is a large difference between the isotropic nature of the scattering from the vitreous at pH 7.4 and the anisotropic scattering from the vitreous samples at pH values of 6.8 and 6.0.

It seemed important to determine if the composition of the gel had changed under acidic conditions in view of the striking physical change. Consequently, additional specimens of vitreous were held at pH 6.0. The gel phase and supernatant solutions were separated subsequently by decanting. The samples then were dialyzed to retain only the high-molecular-weight proteins. After freeze-drying and strong acid hydrolysis, the amino acid analysis was made. The amount of solid material in the supernatant solution was less than 2 percent of the total weight of the gel solids. The analysis showed that 17 amino acids were present in the gel phase. However, neither hydroxyproline nor methionine were found in the protein from the supernatant. The ratio of amino acids in the gel phase were in good agreement with those reported by Swann and Constable,[4] except that the total amount of hydroxyproline was lower than reported. However, no attempt was made in these experiments to separate collagen from other proteins before the amino acid analysis. The amino acid analyses do make it clear that the collagen is in the gel phase and remains there during the growth of turbidity and final collapse of the gel.

Scattering Intensities (t) and Depolarization Ratios (p) of Bovine Vitreous Specimens at Different pH Levels

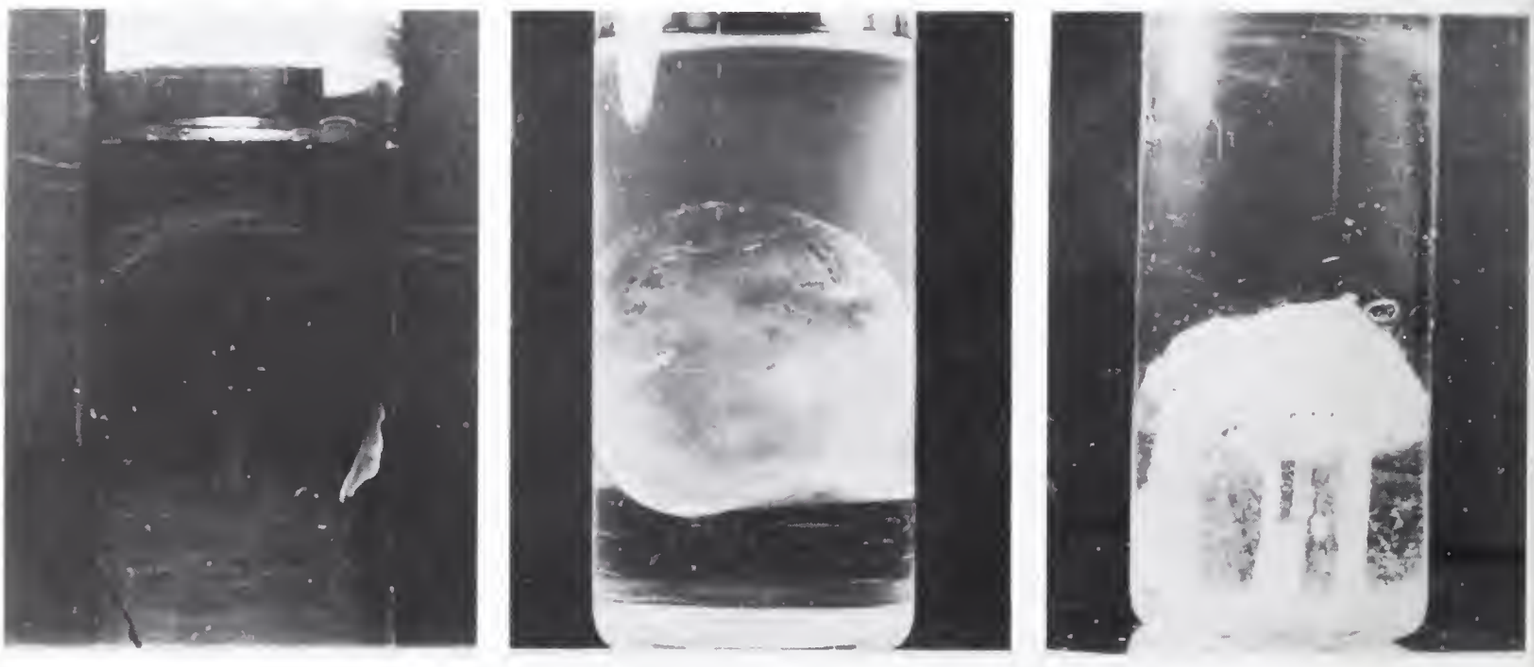
pH	6.0	6.8	New
p	0.15	0.10	0.1
t	5.0	3.0	1.0

Discussion

The vasoconstriction of retinal vasculature has been regarded as an index of oxygen toxicity. It now has been established that the human premature fundus cannot be precisely examined to determine the status of retinal vasculature.[5] The circulatory effects of carbon dioxide, however, are well known. The direct effect on blood vessels produces vascular dilation.[6] The centrally mediated effect on the autonomic system produces peripheral vasoconstriction.[7]

In early human gestation, all the hemoglobin produced is of the fetal variety. Fetal hemoglobin has a great affinity for oxygen, and the fetal oxygen-hemoglobin dissociation curve is shifted to the left due to the lack of 2,3-diphosphoglycerate which is present in adult hemoglobin.[8,9]

The effect of 2,3-diphosphoglycerate might be illustrated by a documented case of twins of 30-week gestation.[10] One twin had received oxygen for four days and developed bilateral, cicatricial retrolental fibroplasia. Her twin sister had received a transfusion of approximately



Bovine vitreous specimens at different pHs: 7.4 (left), 6.8 (center), and 6.0 (right).

35 ml of adult whole blood. The transfused twin received oxygen for 21 days. She has no evidence of RLF, and she has good vision.

Aside from carrying oxygen, hemoglobin has an additional major function of transporting about 20 percent of the carbon dioxide in venous blood draining the tissues. Reduced hemoglobin acts as a base and can take up substantial amounts of acid or carbon dioxide without a fall in pH.[11] The fetal hemoglobin oxygen affinity and the impaired buffering capacity of hemoglobin produces a tissue hypoxia which leads to anerobic glucose metabolism and a severe metabolic acidosis.

Respiratory acidosis is the biochemical consequence of alveolar hypoventilation and, in the human premature, it may be due to hyaline membrane disease, mucus, atelectasis, or congenital cardiopulmonary defects. In addition, there is an increase in pulmonary vascular resistance, increased right-to-left shunt, and a decreased pulmonary perfusion. These factors increase tissue hypoxia and acidosis.[12,13]

Isotopic water studies indicate the vitreal water bed is active and turns over at the rate of about 4 percent per minute or over 50 percent every 15 minutes. Alterations in the pH value of the blood are reflected in a change of the vitreous.[14]

The vitreous is a very dilute equilibrium gel whose structure and dimensions are due to the highly organized state of the residual collagen. A change in this dilute equilibrium gel destroys the transparency of the vitreous by forming heterogeneities large enough to scatter light. In dilute acids, collagen swells enormously—up to 4,500 percent. The great increase in hydration in dilute acids doubtless is due to the breaking of bonds which normally hold the polypeptide chains together.[15]

A recent symposium on RLF was published in English. One of the contributors, R. J. Brockhurst of Boston, presented a study of six patients demonstrating the typical signs of RLF. None had received supplemental oxygen therapy. Three patients were premature, all weighing less than 1.4 kg 168 gm (3 lb 6 oz) at birth. The other three patients were full-term infants; they also showed bilateral signs of RLF.[16]

Gyllensten and Hellström conclude: "Despite the fact that oxygen induced changes in mice as described by us, and other researchers, show great similarities to early stages of human retrolental fibroplasia, it must be pointed out that there is no complete identity as regards the histologic findings. No one has produced, experimentally, the final cicatricial stage of retrolental fibroplasia as seen in human cases." Thus, caution must be observed in drawing conclusions from animal experiments relating to mechanisms producing the disease.[17]

Conclusions have been made regarding the mechanism producing the disease. These have resulted in rigid protocols of oxygen administration. Cross and Bolton have determined the statistical price of preventing retrolental fibroplasia as 16 lives lost for one sight saved.[18,19] A Swedish census of retrolental fibroplasia from 1960 to 1966 may place the cost higher. It included 23 cases of irreversible retrolental fibroplasia in patients receiving less than 40 percent oxygen.[20]

Summary

Oxygen transport in the newborn, usually premature, is affected by altered blood and cardiopulmonary physiology. The vitreous, an avascular, acellular, homogeneous tissue, is a dilute equilibrium gel which is sensitive to pH changes in vitro. This pH change produces an opacification of the vitreous which resembles retrolental fibroplasia. The introduction of weak acids into the ophthalmic vasculature of healthy animals does not produce a change in the presence of normal blood buffers and normal respiratory function. It is difficult to produce the vitreous change in vivo that can be produced in vitro.

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Generic and Trade Name of Drug
Methohexital sodium—Brevital (Eli Lilly and Company)

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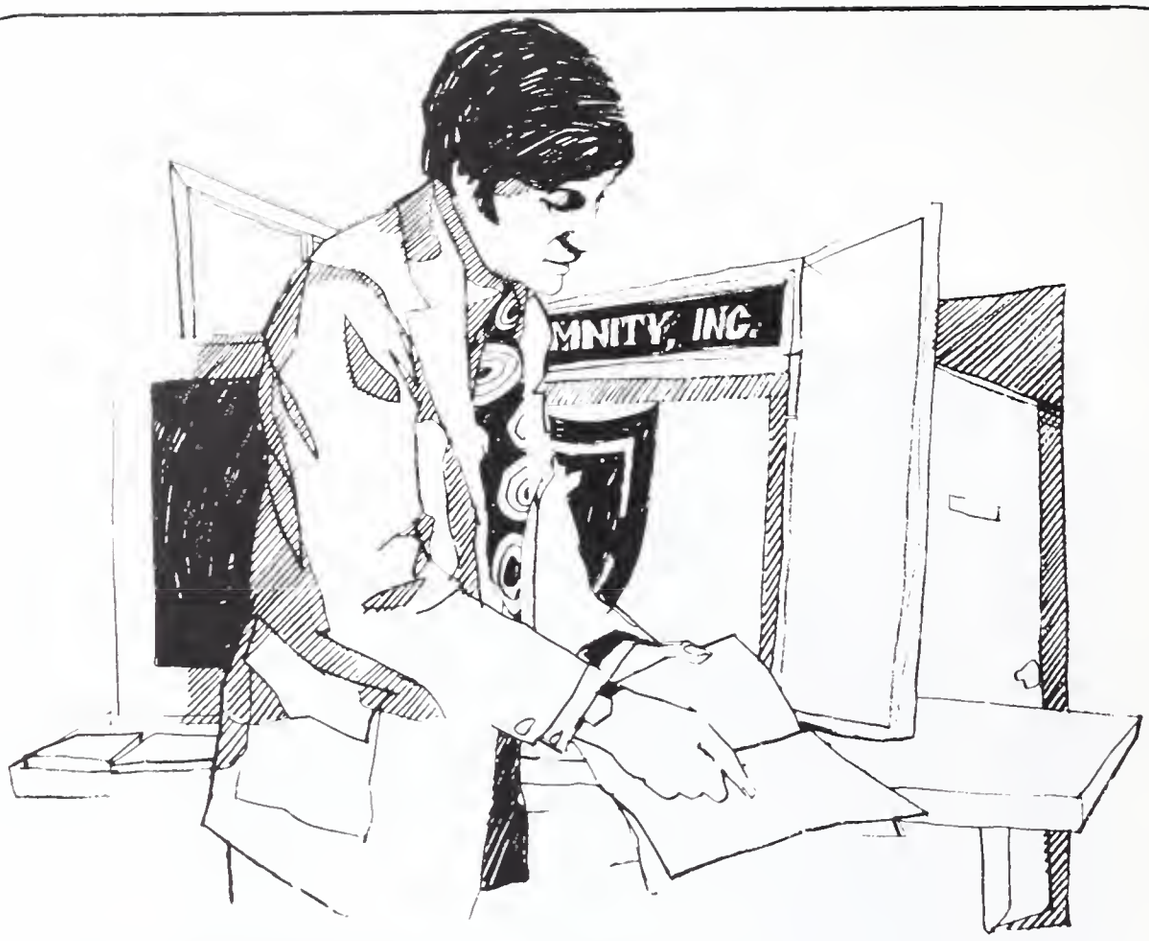
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Immunosuppression and Thyroid Carcinoma

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Patients receiving immunosuppressive agents have an increased risk of cancer. While patients with other types of cancer have been reported, this case is the first in which a thyroid neoplasm has occurred in a patient receiving immunosuppressive agents. Factors relating to the pathogenesis of this tumor are discussed.

THE INCREASED INCIDENCE of cancer arising in patients receiving immunosuppressive agents is of concern to any physician prescribing such drugs. Penn has maintained a registry of such cases.[1] He has stressed the high incidence of neoplasms of the skin, lip, cervix, and histiocytic lymphomas in his series. Thyroid carcinoma has not yet been reported in a patient receiving immunosuppressive agents. While a single case may be only coincidental, we felt that it should be reported for general information and in order to encourage others to report such cases.

Clinical Data

A 24-year-old white woman was admitted to our hospital in July 1974 for treatment of a firm nodule in the right lobe of her thyroid gland. Her past history revealed that she had been hospitalized at our hospital three years previously for icterus, fatigue, and listlessness. At that time, she had been taking multivitamins, Provera® for birth control, and Sumycin® for acne. The patient had a history of bleeding gums. On physical examination in 1971, her thyroid gland was within normal limits, but her liver edge was palpable 5 to 6 cm below the right costal margin. She was icteric and had scattered spider telangiectasia over the arms and upper torso. Positive laboratory values at that time included a hemoglobin level of 9.9 gm/100 ml, white blood cell count (WBC) 2,600/cu mm, with 1 percent bands, 73 percent lymphocytes, 3 percent monocytes, and 2.9 percent reticulocytes. The platelet count was 116,000/cu mm. Serum bilirubin level was 2.5 mg/100 ml direct and 4.5 mg/100 ml total. Serum alkaline phosphatase value was 21 mU/ml (upper normal 35), and serum glutamic pyruvate transaminase (SGPT) 510 mU/ml (normal 45) serum glutamic oxaloacetate transamine (SGOT) 440 mU/ml (normal 40), lactate dehydrogenase (LDH) mU/ml (normal 207), and the Australian antigen was negative. Prothrombin time was 14.1 seconds with a control value of 10.6 seconds; partial thromboplastin time was 36.6 seconds with a control value of 28.6 seconds. Serum albumin level was 3.5 gm/100 ml and there was striking elevation in the patient's gamma globulin on electrophoresis and a total serum bilirubin level of 4.9 mg/100 ml. At that time, the liver scan showed patchy, diffuse decrease in the uptake of technesium-sulphur colloid with increased uptake in the spleen as well. The patient had a markedly positive test for rheumatoid factor with a titer of 1:320. Result of LE preparation test was negative. Antinuclear antibody titer was 1:32 with a serum complement of 98 mg/100 ml. Because of her prolonged prothrombin time, a liver biopsy was not performed. It was felt that she had a chronic, active hepatitis involving an autoimmune process. She was treated initially with prednisone, 40 mg daily. Subsequently, azathioprine was added to the patient's treatment, in a dose of 50 mg daily.

In January 1974, a thyroid nodule had been detected. She had received a course of Synthroid,® 0.2 mg daily, which caused no change in the size of the nodule. At the time of her subsequent admission to another hospital in July 1974, her hemoglobin value was 10.8 gm/100 ml, WBC 2,500/cu mm with 30 percent segmented neutrophils, 5 percent bands, 1 percent basophil, 7 percent monocytes, and 57 percent lymphocytes. Platelet count was

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Submitted September 13, 1976.

20,000/cu mm. Her prothrombin time was 14.4 seconds with a control of 11.9. Her partial thromboplastin time was 31.9 seconds with a control of 29.4. Serum bilirubin level was 0.6 mg/100 ml direct and 0.6 mg/100 ml indirect fraction. Serum alkaline phosphatase was 5.6 mU/100 ml, SGOT 190 mU/100 ml, and SGPT 76 mU/100 ml.

The azathioprine therapy was discontinued, although she continued to take presnisone (15 mg) and Synthroid,® 0.2 mg daily. After gradual improvement of her platelet count, the patient was admitted to this hospital in May 1975 for thyroidectomy. At that time, her hemoglobin level was 11 gm/100 ml, WBC was 3,500/cu mm and normal differential; the platelet count was 100,000/cu mm. Serum calcium value was 8.5 mg/100 ml, and the serum direct biliribin was 1.3 mg/100 ml with a total bilirubin of 1.8 mg/100 ml. The cholinesterase was 37 units with an SGOT of 293 mU/100 ml and SGPT 140 mU/100 ml. Prothrombin time was 14.3 seconds with a control of 11.4 seconds.

Surgery was performed on May 19, 1975. A right thyroid lobectomy was carried out, and frozen section showed papillary carcinoma. Accordingly, a left, subtotal thyroidectomy was performed also. No nodes were found in the tracheoesophageal groove. Pathologic examination disclosed a 2-cm papillary carcinoma in one area of the right lobe of the thyroid with a 0.3-cm follicular, nonencapsulated carcinoma in a separate area of the right lobe. The left lobe showed lymphocytic thyroiditis.

At the time of discharge, the patient was continued on prednisone therapy, 15 mg daily. Subsequently, she has done well with no evidence of recurrence of the neoplasm. The hepatic abnormalities persist unchanged. Her medications are currently Synthroid,® 0.2 mg, and prednisone, 15 mg daily.

Discussion

The etiology of thyroid neoplasia has been reviewed recently by DeGroot and Stanbury.[2] Iodine deficiency, goitrogenic drugs, and roentgen radiation have been implicated. Suppression of thyroid-stimulating hormone (TSH) by the therapeutic use of exogenous thyroxin or dessicated thyroid in thyroid cancer clinically retards tumor growth. Furth has suggested that TSH serves to promote tumor growth while ionizing radiation and certain carcinogens bring about irreversible modifications in the DNA code.[3]

Jones, et al have reported strains of mice in which the spontaneous development of thyroid carcinoma is uncommonly high.[4] The role of iodine deficiency on the formation of thyroid neoplasms was reviewed by Schaller and Stevenson.[5] In the human, genetic susceptibility to medullary carcinoma of the thyroid has been associated with a syndrome involving pheochromocytoma, parathyroid adenomas, neurofibromas, and mucosal neuromas in a relatively small proportion of cases. Possible relationships of papillary carcinoma of the thyroid to Gardner's syndrome are discussed by Camiel, et al,[6] Crail,[7] and Smith.[8] The cases discussed may involve variable degrees of genetic penetrance or expressivity and also may involve interactions with environmental factors since the phenotypic demonstration of the neoplasm is variable.

While circulatory levels of carcinoembryonic antigen (CEA), alpha-feto-protein, and human chorionic gonadotropin (HCG) have helped to identify and follow the activity of various neoplasms, such a test is not yet available for thyroid carcinoma, except for the calcitonic studies in medullary carcinoma of the thyroid. A TSH-like component which cross-reacts with bovine TSH has been found in cancer patients which is not suppressed by thyroid hormone.[9] This may be related to antibovine TSH antibodies.[10] Goudie and McCallum have implied that normal thyroid antigenicity may be lost with dedifferentiation of the neoplastic process.[11] In 1967, Goudie suggested that an immune mechanism is involved in the invasiveness of thyroid cancer.[12] It had been felt that tumor aggressiveness of papillary thyroid carcinoma is lowered when lymphocyte infiltration is marked. Using serum from a patient with Hashimoto's disease as a source of strong, antithyroid, microsomal antibody, antigen-deficient cells were found in cultures of five out of five thyroid carcinomas and in only 6 of 37 non-neoplastic thyroid glands in his study.

Conclusions

Increased incidence of malignant disease has been found to accompany use of immunosuppressive agents. Epithelial tumors involving skin, lip, and cervix are most common. Histiocytic lymphoma is unusually frequent. Prior to this report, thyroid cancer has not been reported in a patient receiving immunosuppressive agents. While one case does not prove cause and effect, it does support the view of previous investigators that an immune mechanism is involved in the clinical development of thyroid cancer. Possible genetic and environmental factors may be involved in the pathogenesis of this tumor.

Generic and Trade Names of Drugs

Medroxyprogesterone acetate — Provera (Upjohn Company)

Tetracycline hydrochloride — Sumycin (E. R. Squibb & Sons)

Sodium levothyroxine — Synthroid (Flint Laboratories)

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Unilateral Hearing Loss And Acoustic Neuroma

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Unilateral hearing loss is the most common symptom in patients in this series who had an acoustic neuroma tumor. The earlier the diagnosis is made and the smaller the tumor, the less the surgical morbidity. Audiometric testing must be done on all unilateral hearing losses to begin the search for an acoustic neurinoma.

EARLY DIAGNOSIS of an acoustic neuroma is important for one reason. The earlier the tumor is found, the smaller its size.[1,2] Furthermore, the smaller the size of the acoustic neuroma at the time of the surgical removal, the less the surgical morbidity. Since this tumor is benign, surgical morbidity is of prime importance. Yet, the majority of these tumors are diagnosed when they are quite large and, therefore, are more difficult to remove.

Surgical morbidity reported in acoustic neuroma surgery includes facial nerve paralysis, gait disturbances, cerebellar dysfunction, and dizziness.[3] Most of these problems can be eliminated by careful surgery with new microscopic operative techniques. Facial nerve paralysis is now occurring less, depending on the size of the tumor; the smaller the tumor, the less facial nerve paralysis. In fact, in the very small tumors, even hearing has been preserved in specific cases.

If an early and common symptom could be pinpointed and emphasized, perhaps more of the smaller tumors would be diagnosed. While much has been written on the symptoms of acoustic neuroma, the literature does not point out the most common symptom. Reported symptoms include tinnitus, dizziness, loss of speech discrimination, and hearing loss. Facial nerve paralysis, fifth and sixth cranial nerve dysfunction, and gait disturbance are symptoms found with the larger tumors.

A survey was made on our series of acoustic neuroma cases to identify an early symptom common to all the patients. Between 1971 and 1976, thirty-one patients underwent excision of an acoustic neuroma. The ages of the individuals were from 18 to 77 years with equal sex distribution. The only symptom common to all the patients was a unilateral hearing loss. The hearing loss had been present from 1 to 20 years before the diagnosis was made. In addition to the hearing loss, the majority of the patients complained of tinnitus. Dizziness or unsteadiness was mentioned by seven patients. Facial nerve paralysis was found in four patients initially, and dysfunction of the trigeminal nerve was noted in two patients. The hearing losses ranged from 30 decibels to total deafness. The discrimination scores were found to be below 50 percent in all but one patient. (Discrimination is the ability of the ear to distinguish speech. While a hearing test measures the amount of sound heard, the discrimination test measures the ability of the ear in understanding speech.)

The acoustic neuroma is a slow-growing tumor and, likewise, the hearing loss is a slow, progressive loss. The only symptom in a small tumor may be a unilateral, progressive hearing loss, but it is difficult to document such an insidious loss of hearing from the patient's history. Therefore, the suspicion of an acoustic neuroma is necessary with any degree of unilateral hearing loss, and a hearing test must be done. While a gross test for hearing is possible as an office procedure, testing for speech discrimination is not feasible. Consequently, audiometry should be done on a unilateral hearing loss to measure both functions of the ear. There is a relationship between the discrimination scores and the hearing levels which may aid in the diagnosis of an acoustic neuroma. If a tumor is suspected, further diagnostic studies should be made. These include specialized audiometry such as the SISI (short increment sensitivity index) test, tone decay, and Bekesy (continuous audiometry). The vestibular system, if involved, is recorded by electronystagmograph. The definitive diagnosis is based on a radiologic study, polytomography of the temporal bone, along with one-cubic-centimeter, intraspinal pantopaque cisternography.

Dr. Owen, Warren, Chief of Neurosurgery, St. Joseph Riverside Hospital.
Dr. Lippy, Warren, Active Staff-Otology, St. Joseph Riverside Hospital.
Dr. Schuring, Warren, Chief of Otology, St. Joseph Riverside Hospital.
Dr. Ziv, Warren, Fellow in Otology, St. Joseph Hospital.
Submitted September 10, 1976.
Reprint requests to Warren Otologic Group, 3893 East Market Street, Warren, Ohio 44484 (Dr. Schuring).

(continued from page 219)
In the larger tumors, plain x-ray films of the temporal bone, cisternography with a larger volume of pantopaque, and computerized tomographic scanning techniques are helpful.

All 31 of the patients underwent excision of their acoustic neuroma tumors. The size of the tumors ranged from 1.5 to 5.0 cm. There was no surgical mortality. Long-term surgical morbidity was limited to facial nerve paralysis in 48 percent of the patients. The larger the tumor, the more chance of facial nerve paralysis was noted in our patients. A second procedure, hypoglossal-nerve-to facial-nerve anastomosis, was performed in one-half of the patients with nerve paralysis, and gave partial return of facial function in all cases.

Conclusion

Our conclusion points to the unilateral hearing loss as being the most common symptom in acoustic neuroma patients. All patients with unilateral hearing loss need audiometric testing of both functions of the ear-sound level and discrimination of speech.[4,5] A decision then must be made by an otologist or otolaryngologist as to whether further testing is necessary to continue the search for a possible acoustic neuroma. Early diagnosis will lessen both the surgical morbidity and the risk for the patient.[3]

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Current Knowledge Associated With Temporomandibular Joint Syndrome

Ernest Pagonis, D.D.S.

Temporomandibular joint syndrome which is characterized by pain, muscle tenderness, limitation or alteration of mandibular movement, and clicking in the joint(s), has been a source of controversy in both the medical and dental professions for the past half century.

This is due to the fact that, with this syndrome, we are dealing primarily with the very complex stomatognathic system whose component parts are very delicately and functionally interrelated.

We now recognize that the emotionally stressed patient is the prime candidate, and that the masticatory apparatus is the trigger mechanism in this syndrome.

The concerted efforts of physician and dentist are needed to resolve this most perplexing and yet common problem.

THE PURPOSE OF THIS ARTICLE is to present a brief yet factual synopsis relating to the problem of temporomandibular joint (TMJ) pain-dysfunction syndrome (TMJ syndrome).

This entity was first described in the literature by Monson around 1920.[1] Costen later elaborated on these articles, and the entity became known as Costen's syndrome.[2] In short, Costen stated that pain associated with the TMJ area is due to the impingement of the auriculotemporal nerve by the distal displacement of the mandibular condyle. This theory has since been repudiated by the late and foremost anatomist and physiologist, Dr. Harry Sicher.[3]

Another popular school of thought is that this syndrome is an entirely psychiatric problem. Dr. Sigurd Ramfjord, et al of the University of Michigan have completed an extensive study which shows that less than 5 percent of severe TMJ pain suffers require psychiatric care.[4]

We now have come to recognize that a true TMJ syndrome involves muscle spasm. The muscles most often involved are the pterygoid muscles, principally the lateral pterygoids.[5] The other muscles of mastication and those of the neck and shoulders also may be involved in this syndrome.

Important factors also related to this problem include emotional stress of the patient and malocclusion of the teeth. Malocclusion is considered to be the trigger mechanism which places the pterygoid muscles in spasm through a neuromuscular reflex action; it is believed to be the principle cause of TMJ pain.[5] Electrolyte imbalance and/or hormonal deficiency in the patient also may play a role in the muscle spasm.

Other factors associated with facial pain, which may mask the signs of true TMJ syndrome and make diagnosis difficult include: TMJ arthritis, odontalgias, sinusitis, myalgias, neuralgias (tic douloureaux), Meniere's disease, headache, temporal arteritis, angina pectoris, otitis, and neoplasms.

When this syndrome is suspected and the attending physician wishes to screen the patient, the following procedures are suggested:

1. A close visual examination of the opening movement of the mandible. Any deviation left or right of normal opening indicates spasm of the muscles which are involved in the functional movement of the temporomandibular joint.

2. By using the stethoscope, a clicking and snapping of the joint(s) can be detected if a disharmony exists between the articular disc of the particular joint(s) and the associated musculature.

3. Limited mandibular opening accompanied by pain in the joint area. This observation can be carried a step further to verify the possibility of a malocclusion as the causative factor. This can be accomplished by placing a small roll of gauze between the patient's upper and lower front teeth in order to separate them. Usually within five or ten minutes, the patient will be able to open wider upon removal of the gauze—another indication that we may be dealing with muscle spasm.

Dr. Pagonis is in the private practice of dentistry in Canton, and a member of the Courtesy Staffs, Aultman and Timken Mercy Hospitals, Canton; and Doctor's Hospital, Massillon.

Submitted September 16, 1976.

A differential diagnosis performed by the skilled clinician provides a definitive diagnosis and includes:

1. A brief medical and dental history for determining the possibility of other contributing factors to the syndrome.

2. Gentle intraoral palpation of the pterygoid muscles to determine if they are in spasm.

3. Precise manipulation of the mandible to bring it to its most posterior-superior position (terminal hinge position) in order to determine if dental discrepancies in the occlusion are present upon complete closure of the teeth.

4. Radiographs of the joint area to rule out the presence of neoplasms, cysts, fractures, or joint pathology, which could contribute to the syndrome.

If the second and third findings in the differential diagnosis are present, then correct occlusal therapy would be indicated as a first step in treating the discomfort. This usually is performed by the same clinician who makes the differential diagnosis.

A dentist knowledgeable in TMJ therapy and with advanced training in occlusion could serve as consultant to the physician and help in resolving this perplexing problem with predictable success.

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Candidates for OSMA President-Elect



Dr. Gaughan



Dr. Hogg

John J. Gaughan, M.D., Cleveland

John J. Gaughan, M.D., has been nominated for the office of President-Elect of the OSMA by the Academy of Medicine of Cleveland. Academy President George P. Leicht, M.D.., wrote in his letter of nomination:

By constitutional privilege, the Academy of Medicine of Cleveland, Ohio (the Cuyahoga County Medical Society), enthusiastically nominates John J. Gaughan, M.D., for the office of President-Elect of the Ohio State Medical Association, which election will take place in May 1977 at the Annual meeting of the House of Delegates of the Ohio State Medical Association.

Doctor Gaughan is eminently qualified for this position since he is a member of the Academy of Medicine of Cleveland, the Ohio State Medical Association, and the American Medical Association.

I have been informed by Manoochehr Meshginpoosh, M.D.; Wei-Tien Pien, M.D.; and Ronald J. Taddeo, M.D., presidents respectively of Ashtabula, Geauga, and Lake County Medical Societies, that these societies have also indicated their support for Doctor Gaughan and thus, the entire Fifth District supports his nomination.

Physicians in the counties of the Fifth District believe that Dr. Gaughan is uniquely qualified to lead the OSMA.

Dr. Gaughan graduated from St. Louis University School of Medicine in 1946. After interning at St. John Hospital, Cleveland, he completed a radiology residency at Crile Veterans Administration Hospital. He was certified by the American Board of Radiology in 1952.

Dr. Gaughan is currently serving as the OSMA Fifth District Councilor. He has also been an Alternate Delegate from Ohio to the AMA for the past two years. In addition, Dr. Gaughan is a Past President of the Academy of Medicine of Cleveland where he is on the Medical Advisory Committee to Blue Cross of Northeast Ohio and the Board of Directors of Academy Services, Inc. During his years in county and state medical association activities, he was chairman or member of such committees as ethics, membership, public relations, and peer review.

A Fellow of the American College of Radiology, Dr. Gaughan is also a member of the Radiological Society of North America; Eastern Radiological Society; Ohio State Radiological Society; and Cleveland Radiological Society, of which he was president. Dr. Gaughan is also a Trustee of the Cuyahoga County Medical Foundation and a member of the boards of Magnificat High School in Cleveland, and the Cleveland Club of St. Louis University. He was president of both organizations.

Dr. Gaughan is affiliated with St. John Hospital, Cleveland, where he has been President of the Medical Staff since 1973 and is a member of the Board of Trustees.

Dr. Gaughan and his wife, Alma, are the parents of five daughters.

Stephen P. Hogg, M.D., Cincinnati

Stephen P. Hogg, M.D., has been nominated for the office of President-Elect of the OSMA by the Academy of Medicine of Cincinnati. In his letter of nomination, Academy President Stanley J. Lucas, M.D., wrote:

The Council of the Academy of Medicine of Cincinnati has voted unanimously to nominate Stephen P. Hogg, M.D., Councilor First District, for the Presidency of the Ohio State Medical Association. Dr. Hogg's candidacy was placed before the Council by Stewart B. Dunsker, M.D.

The Council feels that Dr. Hogg is especially qualified for this important position by virtue of his activities and accomplishments locally and statewide. Dr. Hogg has been a tireless and dedicated worker for the interests of medicine here in Cincinnati, both as Past President of the Academy and current President of the Midwest Foundation for Medical Care, Inc.

The membership of the Academy of Medicine strongly supports Dr. Hogg's candidacy, and we all feel that he will make an excellent President of our state organization.

Dr. Hogg received his medical degree from the University of Louisville in 1944 after which he served an internship at the U.S. Naval Hospital, Pearl Harbor, Hawaii. He also completed a residency in otolaryngology at the University of Cincinnati College of Medicine, Cincinnati General Hospital. He was certified by the American Board of Otolaryngology in 1950.

Dr. Hogg is currently serving the OSMA as First District Councilor. He is also President of the Midwest Foundation for Medical Care; Vice President of the Regional Association of County Medical Societies; and a member of the Board of Trustees of the Statewide Health Coordinating Council, the American Association of Foundations for Medical Care, the Cincinnati Speech and Hearing Center, and the Health Resources Coordinating Center.

In addition, he has been President of the Cincinnati Academy of Medicine, the Ohio State Otolaryngology Society, and the Cincinnati Otolaryngology Society. Dr. Hogg is also Past Chairman of the Medical Advisory Committee of Blue Cross of Southwest Ohio.

An Associate Clinical Professor of Otolaryngology at the University of Cincinnati College of Medicine, Dr. Hogg is in private practice in the specialty of ear, nose, and throat in Cincinnati. He is on the Attending Staffs at Cincinnati General, Children's, Christ, Bethesda, and Deaconess Hospitals, Cincinnati. He is on the Courtesy Staff of Good Samaritan Hospital, Cincinnati.

Dr. Hogg is married to the former Carldean Taylor. They are the parents of six children, one of whom is deceased.

Resolutions for 1977 House of Delegates

Editor's Note: *The following resolutions affecting the Ohio State Medical Association Constitution and Bylaws have been submitted for consideration by the OSMA House of Delegates at the 1977 Annual Meeting. (Any such resolutions not received by Journal deadline are not printed herein.) A pamphlet containing all resolutions may be obtained by contacting OSMA Headquarters Office, 600 S. High Street, Columbus 43215, telephone: 614/228-6971.—L.A.J.*

RESOLUTION NO. 1-77

Proposed Amendment to the Bylaws to
Define Valid Ballots in Elections
(By the OSMA Council)
Fiscal Note: 0

WHEREAS, Delegates and alternate delegates to the American Medical Association have been chosen by a method of voting referred to by *Sturgis* (OSMA Parliamentary authority) as "Simultaneous election of candidates to several positions of equal rank," and

WHEREAS, This method of voting has resulted in some instances in the past of ballots being cast containing fewer votes than the number of positions to be filled, and

WHEREAS, The impact of ballots cast containing fewer votes than the number of positions to be filled gives an advantage to those candidates voted for and a disadvantage to those candidates not voted for, THEREFORE, BE IT

RESOLVED, That Chapter 5, Section 7 of the Bylaws be amended by adding at the end of the third and last paragraph the following: "No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee." (For example: If upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for four (4) of the nominees for such positions.)

RESOLUTION NO. 2-77

Appointment Procedures for Committees for
This Association
(By the OSMA Council)
Fiscal Note: 0

WHEREAS, With the expansion of medical science and technology, as well as the many different facets which affect medicine; and

WHEREAS, The Bylaws of the Association were developed many years ago not taking into consideration that the necessity to establish many more committees would be necessary; and

WHEREAS, Upon several occasions some deletions and additions have been made in the number of Standing Committees; and

WHEREAS, Even though there are five (5) such committees there are a number of Special Committees which are as significant to the medical science and technology of the Association as the Standing Committees; and

WHEREAS, There is no provision in the Bylaws to replace a member who is not active and fails to participate within that five (5) year appointment, NOW, THEREFORE BE IT

RESOLVED, That Chapter 9 of the current Bylaws be deleted and a new Chapter 9 be substituted as follows:

Chapter 9
Committees

SECTION 1. Titles of Committees. The standing committees of this Association shall be the following:

1. Committee on Public Relations
2. Committee on Scientific Work
3. Committee on Education
4. Committee on Judicial and Professional Relations
5. Committee on Membership and Planning

Other committees of this Association shall be those designated in Sections 4 and 7 of Chapter 4; Section 1 of Chapter 5 and Section 5 of Chapter 7, and such special committees as may be appointed by the President.

SECTION 2. Appointment. Each year the President, with the approval of the Council, shall appoint the members of all standing and special committees. Each appointment is for a term of one year unless a vacancy occurs, the President, with the approval of The Council, would fill the vacancy for the remainder of the term.

SECTION 3. Duties and Responsibilities of Committees. Each standing and special committee shall consider all items referred by the House of Delegates and The Council. The purpose(s) of each committee shall be prescribed by The Council.

The actions of all standing and special committees shall be subject to the approval of the Council.

RESOLUTION NO 3-77

Creation of House Officers Section
(By Allen J. Zobay, M.D., Cincinnati, and
Robert M. Benson, M.D., Akron)
Fiscal Note: $250

WHEREAS, Residents in the State of Ohio have a genuine vested interest in the business of organized medicine within this state and the nation; and

WHEREAS, The need for solidarity within the medical profession is ever increasing as numerous special interest groups and governmental agencies continue the assault on the physician-patient relationship; and

WHEREAS, The AMA formed an Intern/Resident Business Session in 1972 giving House Officers voting positions on all major AMA policy boards and a voting delegate to the House of Delegates; and

(continued on page 228)

The OSMA Annual Meeting Social Function Presents

The Buddy Young Orchestra and Show

An Evening of Dining and Dancing

Tuesday, May 17

6:30 PM

Ballroom, Neil House, Downtown Columbus

Join your OSMA friends and their spouses on Tuesday evening, May 17, for a night of merriment. The Neil House will be the setting for dining and dancing. A social hour precedes a delicious beef dinner, after which music and entertainment will be provided by the Buddy Young Orchestra. Tickets, priced at $20 per person, may be purchased by using the form appearing on the following page.

The music and entertainment promise an enjoyable evening, for 1977 has its own counterpart to the big bands of yesteryear. In the past, it was Tommy Dorsey, Glenn Miller, Artie Shaw, and many others. Today, sweeping the country is Buddy Young, his saxophone and his orchestra. They play it all— music to satisfy the dancer and the listener of every generation. A constant panorama of sound punctuated with an ever-changing pattern of lighting and motion. The sweet sounds of the big band era: country ballads to contemporary rock, pop-gospel to twist, Broadway show tunes to Dixieland. You name it: Buddy will play it.

(See following page for registration form.)



General Session:

Consumer Attitudes Toward Health Care and Medical Malpractice

Monday, May 16, 1:30-3:30 PM

Veterans Memorial

Physicians and their spouses are urged to attend this educational session devoted to the consumer's thoughts about health care. During late 1976, a public opinion survey was conducted on behalf of the OSMA by Management Horizons, Inc., Columbus. This survey dealt strictly with Ohio consumers; and with its tabulation, the OSMA has a good idea of Ohioan views on physicians, health care, and malpractice.

All the information is being compiled into a book, but this session provides an early glimpse of the findings. Roger Blackwell, Ph.D., Vice President of Management Horizons, Inc., will make the presentation.

Dr. Blackwell states: "Between 1970 and 1975, the number and magnitude of malpractice suits skyrocketed and yet no dramatic or sudden changes had occurred among physicians which would have accounted for the revolution in malpractice litigation. If anything, the increases probably led to more cautious and defensive practice by physicians. It is clear, therefore, that an understanding of malpractice claims must start with a description of the environment in which health care operates."

The information gathered is invaluable to Ohio physicians concerned about the current malpractice crisis. But, the data may be a wider appeal. Dr. Blackwell explains this appeal in his soon-to-be-released book: "Every state varies in its environment for health care and the results in Ohio are not necessarily applicable to another specific state. Nevertheless, to a degree Ohio is a microcosm of the entire United States. Thus, we believe the findings in this study can generate useful thinking about the problems of health care and malpractice on a broader geographic scale."

Annual Meeting Courses, OMPAC Luncheon, and Social Function

REGISTRATION FORM

Please register me for the following Annual Meeting activities:

☐ Postgraduate courses, May 17 & 18: — Fee: $20

1st Choice: Course No._____

2nd Choice: Course No._____

3rd Choice: Course No._____

☐ Dermatology for the Non-Dermatologist, May 17 — Fee: $75

☐ Ethical Dilemma of Crisis Medicine, May 14 — Fee: None

☐ Negotiating, May 14 & 15 — Fee: $125 OSMA Members, $175 Non-Members

☐ Public Speaking, May 14 & 15 — Fee: $130 OSMA Members, $145 Non-Members

☐ OMPAC Luncheon, May 17 — Fee: $10 per person

☐ Social Function, May 17 — Fee: $20 per person

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Resolutions *(continued)*

WHEREAS, AMA Executive Vice President James H. Sammons, M.D., has stated publicly that active participation by Residents is vital to the future of the Federation and the solidarity of the medical profession; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association form a House Officers Section to provide a forum within the State Association for the exchange of information among young physicians in training and their more senior colleagues; and BE IT FURTHER

RESOLVED, That the President of the Ohio State Medical Association appoint a committee to determine the appropriate organization and necessary changes to the Ohio State Medical Association Constitution and Bylaws to create a House Officers Section; and BE IT FURTHER

RESOLVED, That the Committee report to the Ohio State Medical Association House of Delegates at its next session the recommended organization and changes to the Ohio State Medical Association Constitution and Bylaws to create a House Officers Section.

RESOLUTION NO. 4-47

Delegate Representation for Small Counties
(By Morgan County, Noble County, and Eighth District Councilor)

WHEREAS, A number of component societies in rural counties have a very small membership; and

WHEREAS, It is difficult for delegates from these counties to obtain coverage for their practice in order to attend meetings of the House of Delegates; and

WHEREAS, Such a lack of representation disenfranchises the members of that component society and reduces the voting power of that councilor district, THEREFORE, BE IT

RESOLVED, That Article 4, section 2 of the Bylaws be amended by adding the following in paragraph 2, line 5 after the words "Active member in good standing":

"from that society or from another component society within the same councilor district."

RESOLUTION NO. 5-77

Special Meetings of OSMA
(By Stark County Medical Society)

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WHEREAS, Article V, Section 3 of the Constitution of the OSMA presently allows a special meeting of the House of Delegates upon a "petition duly authorized and signed by the governing bodies of at least thirty (30) component societies"; and

WHEREAS, The term "governing bodies" is unclear; and

WHEREAS, The requirement of a minimum of thirty (30) component societies effectively precludes the possibility of a special meeting of the House of Delegates of OSMA by the petition method; THEREFORE, BE IT

RESOLVED, That Article V, Section 3, of the OSMA Constitution be amended to permit the calling of a special meeting of the House of Delegates of OSMA upon a "petition duly authorized and signed by the presidents of at least ten (10) component societies."

RESOLUTION NO. 6-77

Special Sessions of the House of Delegates
(By the Fifth Councilor District)
Fiscal Note: $20,000

WHEREAS, The issues facing organized medicine are increasing in numbers and complexity; and

WHEREAS, It is virtually impossible to anticipate when a vital issue requiring a timely response will arise; and

WHEREAS, The Council and the Officers of OSMA will be in a stronger position to respond to issues once they have received the input of the House of Delegates; THEREFORE, BE IT

RESOLVED, That appropriate changes in the Constitution and Bylaws of the Ohio State Medical Association be made to require semi-annual sessions of the House of Delegates.

RESOLUTION NO. 7-77

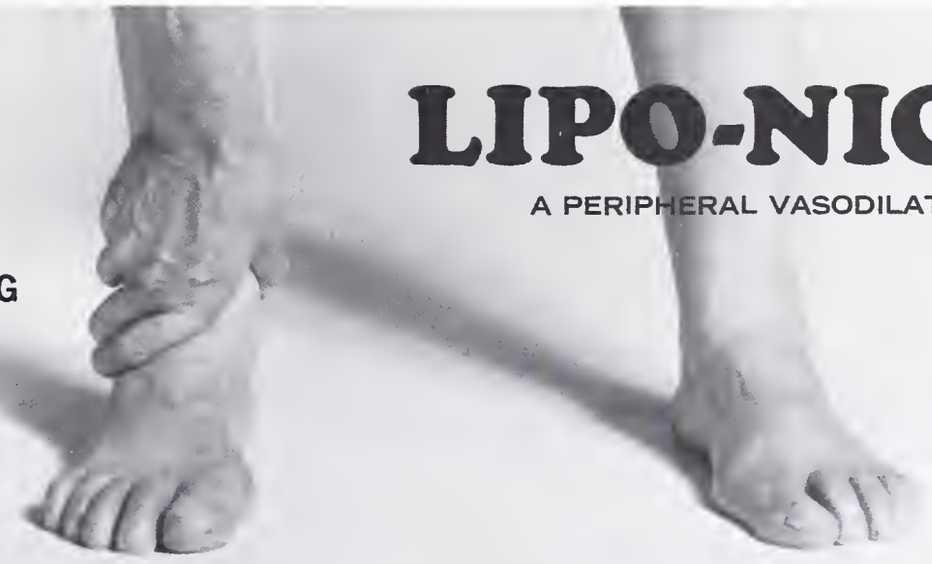
Professional Expert Witness
(By the Council of the Academy of Medicine of Columbus and Franklin County)

WHEREAS, The role of the expert witness has not been defined in the Code of Regulations of the Ohio State Medical Association; and

WHEREAS, The problem of the professional expert witness has been with us for many years, but has not been openly confronted by organized medicine; and

(continued on page 230)

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN

A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL

nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
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Annual Meeting Specialty Section Programs

Editor's Note: *The specialty section programs listed below have been received or altered recently. The March 1977 issue of* The Journal *contains other offerings (see page 160).—L.A.J.*

COLON AND RECTAL SURGERY

CME Hours: 1 Category I
Date: Wednesday, May 18
Time: 1:30-3:45 PM
Sponsor: OSMA Section on Colon and Rectal Surgery, and the Ohio Valley Society of Colon and Rectal Surgery
Course Director: *Carlos O. Andarsio, M.D.,* Chairman, OSMA Section on Colon and Rectal Surgery, Springfield.

1:30 PM Ischemic Colitis— Patrick F. Hagihara, M.D., Assistant Professor of Surgery, University of Kentucky, Lexington, Kentucky
2 PM Discussion
2:15 PM Break
2:30 PM Surgical Management of Crohn's Disease— Victor W. Fazio, M.B., B.S., Head, Department of Colon and Rectal Surgery, Cleveland Clinic Foundation, Cleveland
3 PM Surgical Management of Diverticulitis— Dan W. Elliott, M.D., Chairman, Department of Surgery, Wright State University, Dayton
3:30 PM Discussion

EMERGENCY MEDICINE

CME Hours: 2 Category I
Topic: Ohio Committee on Trauma
Date: Tuesday, May 17
Time: 12 NOON-4:30 PM
Sponsor: Ohio Committee on Trauma and OSMA Section on Emergency Medicine
Course Director: *Robert Zollinger, Jr., M.D.,* President, Ohio Committee on Trauma, Cleveland

12 NOON Luncheon Meeting— Sheraton, Moderator: Richard B. Fratianne, M.D., F.A.C.S., Cleveland
1:30 PM Cardiorespiratory Support by EMT/A's Enroute to the EW— Mr. Rocco Morano, Columbus
1:50 PM Indications for Emergency Intubation— Thomas Beach, M.D., Columbus
2:10 PM Have EMT's Altered the Outcome of Acute MI's?— Richard W. Watts, M.D., Cleveland
2:30 PM Where did the Heartmobile Go?— John M. Stang, M.D., Columbus
2:50-3 PM Question-and-Answer Session, Moderator-Robert M. Zollinger, Jr., M.D., F.A.C.S., Cleveland
3-3:15 PM Coffee Break
3:15 PM Vasoactive Drugs for CV Emergencies— Terrence Horrigan, M.D., Cleveland
3:35 PM Emergency CV Operations and Bypasses— John S. Vasko, M.D., Columbus
3:55 PM Shock Lung Treatment in 1977— Joseph C. Avellone, M.D., Cleveland
4:15-4:30 PM Question-and-Answer Session

RHEUMATOLOGY

CME Hours: 3 Category I
Topic: Clinical Evaluation and Treatment of the Rheumatic Diseases
Date: Monday, May 16
Time: 1:30-5 PM
Sponsor: OSMA Section on Rheumatology and The Ohio Rheumatism Society
Course Director: *Richard H. Turner, M.D.,* Columbus

1:30 PM History of Physical Examination in Differentiating the Rheumatic Diseases— Robert Sheon, M.D., Toledo
1:50 PM Synovial Fluid Analysis and Synovial Biopsy — Robert Zipf, M.D., Columbus
2:10 PM Radiology and Nuclear Medicine— Sebastian A. Cook, M.D., Cleveland
2:30 PM Arthroscopy: Synovial Diseases— Movie made by Lanny Johnson, M.D., East Lansing, Michigan
2:50 PM Discussion
3:10 PM Break
3:30 PM What Is New in the Medical Management of Adult Rheumatic Disease?— Norman O. Rothermich, M.D., Columbus
3:50 PM What Is New in the Medical Management of Juvenile Rheumatic Disease?— Jack Bass, M.D., Columbus
4:10 PM What Is New in the Orthopedic Management of Rheumatic Disease?— Edward Miller, M.D., Cincinnati
4:30 PM Discussion

Resolutions *(continued)*

WHEREAS, This is one of the few areas where the Ohio State Medical Association House of Delegates can take positive action by helping to correct the malpractice crisis independent of the State Legislature; THEREFORE, BE IT

RESOLVED, That testifying as an expert witness in a malpractice case outside the specialty of the physician, represents unethical conduct and in the future any physician who testifies as an expert witness outside of his specialty (or logical extension of his field of expertise) will after due process be subject to expulsion from the Ohio State Medical Association and this fact shall be publicized.

The Bylaws of the Ohio State Medical Association shall be changed to read that the intent of this resolution is carried out; and BE IT FURTHER

RESOLVED, That the Ohio delegation to the American Medical Association House of Delegates be instructed to pursue similar action at the national level.

MAKE YOUR HOTEL RESERVATIONS
for the
1977 OSMA Annual Meeting
COLUMBUS, OHIO — MAY 14-18

Sheraton-Columbus Motor Hotel
50 North Third Street
(OSMA Headquarters)

Singles	$30.00
Doubles	$37.00
Suites	$78.00

Neil House Motor Hotel
41 South High Street
(OSMA Co-Headquarters)

Singles	$24.00
Doubles	$30.00
Twins	$32.00
Suites	$65.00 - $150.00

Christopher Inn
300 East Broad Street
(Auxiliary Headquarters)

Singles	$20.50 - $29.00
Doubles	$26.00 - $35.00
Twins	$30.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 14-18, 1977 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1977.)

_____ Single Room _____ Twin Room

_____ Double Room Other Accommodations _____

Price Range _____ Guaranteed _____

No. of Persons _____ Arrival Date _____ Hour of Arrival _____ Departure Date _____

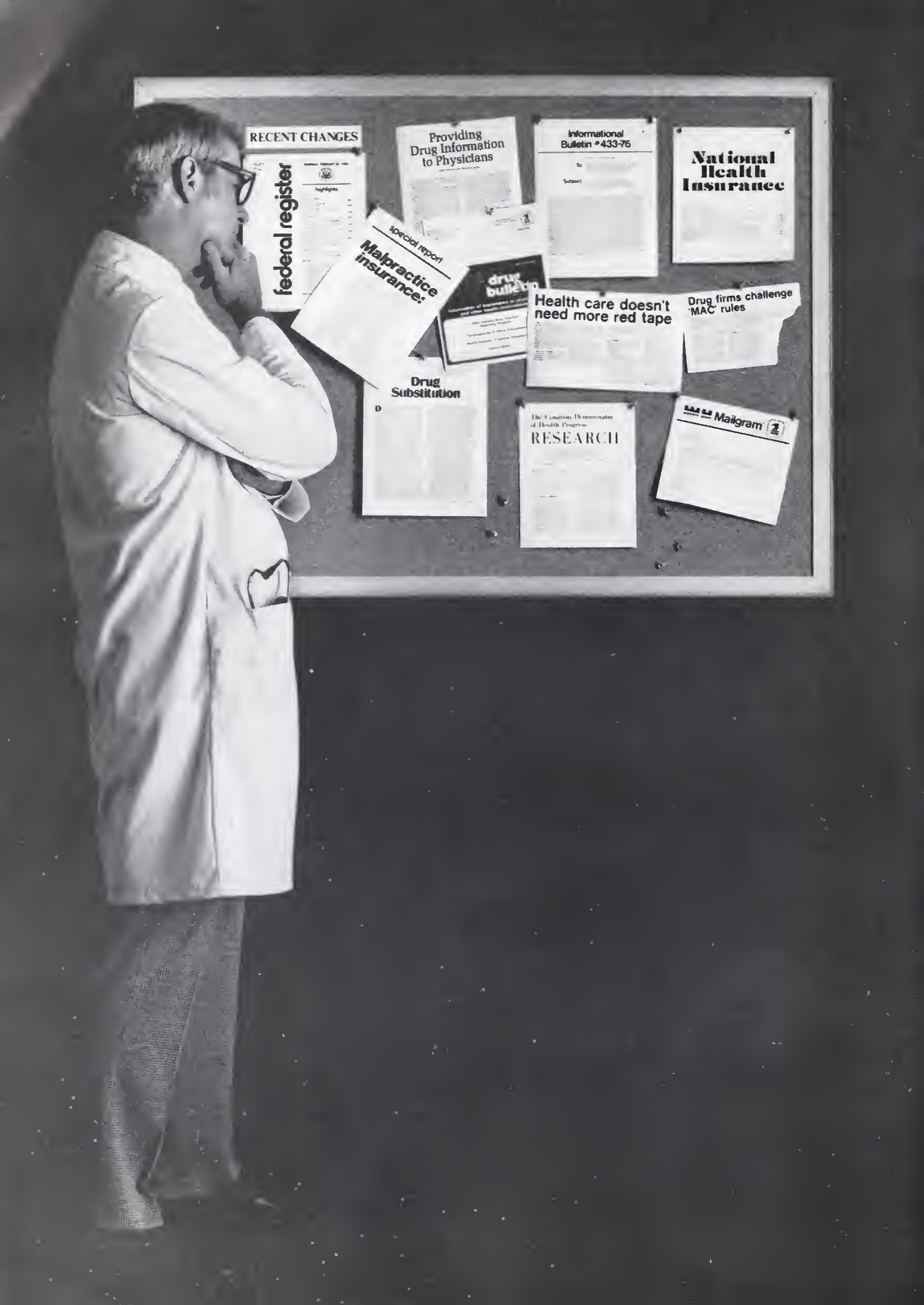
Name _____

Address _____

City _____ State _____ Zip _____

PLEASE VERIFY MY RESERVATION
If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.

Rooms will be held until 6:00 P.M. unless payment is guaranteed.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

1977 Annual Meeting Schedule

Saturday, May 14

8 AM — **Registration**
Sheraton: Terrestrial Promenade, 2nd floor

9 AM - 5 PM — **Public Speaking Seminar**
Sheraton: Venus Room, 2nd floor
(Continued on Sunday, May 15)

8 AM - 9:30 PM — **Art of Negotiating**
Sheraton: China-Malay & Baltic Rooms, 2nd floor
(Continued on Sunday, May 15)

2 - 5 PM — **Ethical Dilemma of Crisis Medicine**
Sheraton: Taft Room, 3rd floor

Sunday, May 15

9 AM - 12 NOON — **Public Speaking Seminar**
Sheraton: Venus Room, 2nd floor
(Continuation of Saturday, May 14)

8 AM - 12:30 PM — **Art of Negotiating**
Sheraton: China-Malay & Baltic Rooms, 2nd floor
(Continuation of Saturday, May 14)

2 - 4 PM — **OSMA Delegation to AMA**
Sheraton: Board Room, 21st floor

3 - 7 PM — **Registration for OSMA House of Delegates**
Sheraton: Terrestrial Promenade, 2nd floor

4 PM — **Councilor District Caucuses**
(Rooms to be posted)

5:30 PM — **Buffet Dinner**
Delegates, Alternates, OSMA Council, and Official Guests
Sheraton: Venus and Mars, 2nd floor

7 PM — **OSMA House of Delegates First Business Session**
Sheraton: Jupiter & Saturn, 2nd floor

9 PM — **Reception** (Cash Bar)
Sheraton: Oceanic Suites, 2nd floor

Monday, May 16

8:30 AM - 12 NOON **Reference Committee Hearings**
Res. Com. No. 1, Sheraton: Venus Room, 3rd floor
Res. Com. No. 2, Sheraton: Taft Room, 2nd floor
Res. Com. No. 3, Sheraton: Grant Room, 3rd floor
President's Address, Sheraton: Garfield-Hayes, 3rd floor
Com. on Nominations, Sheraton: Harrison, 3rd floor

8 AM — **Registration-Reference Committees**
Sheraton: Promenade Area

8:30 AM — **General and Advance Registrations Opens**
Veterans Memorial: Ground Floor

11 AM — **Opening Sessions-Ohio Health Commissioners**
Veterans Memorial: Room 205

11:30 AM — **Luncheon, Section on Psychiatry and Neurology and Ohio Psychiatric Association**
Sheraton: Mediterranean-Caribbean, 2nd floor

12 NOON — **All Exhibits Open**
Veterans Memorial

12 NOON — **Luncheon, Section on Neurology**
Sheraton: China-Malay, 2nd floor

12 NOON - 1:30 PM **Tour of Exhibits**
Veterans Memorial

12 NOON — **Luncheon, Section on Rheumatology and Ohio Rheumatism Society**
Sheraton: Baltic North, 2nd floor

1:30 PM — **Continuation of Reference Committee Hearings** (if necessary)

1:30 - 4:30 PM — **Section on Otolaryngology and Ohio Society of Otolaryngology**
Veterans Memorial: Rooms 203 and 204

1:30 - 5:30 PM — **Section on Psychiatry and Neurology and Ohio Psychiatric Association**
Veterans Memorial: Room 201

1:30 PM — **General Session: Consumer Attitudes Toward Health Care and Medical Malpractice**
Veterans Memorial: Assembly Hall

1:30 - 5 PM **Section on Rheumatology and Ohio Rheumatism Society**
Veterans Memorial: Rooms 206-207

1:30 - 4:30 PM **Section on Neurology**
Veterans Memorial: Room 208

1:30 PM **Ohio Health Commissioners**
Veterans Memorial: Room 205

4:30 PM **Close Exhibits for Monday**

5 -6 PM **Reception for Exhibitors**
Sheraton: Oceanic Suites, 2nd floor

Tuesday, May 17

7:30 - 9:30 AM **Five Postgraduate Courses**
Course I—Clinical Management of Electrolytes and Acid-Base Disturbances
Sheraton: Venus Room

Course II—Neurology Revisited
Sheraton: Auditorium

Course III—The Laboratory—How It Can Help Your Practice
Sheraton: Mediterranean-Caribbean

Course IV—Sound Prescription of Common Drugs
Sheraton: Baltic North

Course V—Pulmonary Physiology
Sheraton: China-Malay

8 AM **Association of County Medical Society Executives' Breakfast**
Sheraton: Grand Room, 3rd floor

8 AM **OMPAC Board Breakfast and Meeting**
Sheraton: Harrison Room, 3rd floor

8 AM **Governors Meeting Ohio Ophthalmological Soc.**
Scioto Country Club, Columbus

8:30 AM **General and Advanced Registration Opens**
Veterans Memorial: Ground floor

8:30 AM - 12 NOON (All Day) **Dermatology Course**
Sheraton: Venus Room, 2nd floor

9 AM **All Exhibits Open**
Veterans Memorial

11:30 AM **Ohio Chapter, American College of Chest Physicians** (All Day)
Veterans Memorial: Rooms 206-207

9 AM - 12 NOON (All Day) **Section on Otolaryngology and Ohio Society of Otolaryngology**
Veterans Memorial: Rooms 203-204

9 AM - 12 NOON (All Day) **Section on Pathology and Ohio Society Pathologists**
Veterans Memorial: Room 201

9 AM **Essential Life Support Course**
Veterans Memorial: Ground floor, exhibit area

9 AM **Section on Internal Medicine and Ohio Society of Internal Medicine**
Veterans Memorial: Room 202

9 AM **Ohio Health Commissioners Institute**
Veterans Memorial: Room 205

9 AM - 12 NOON **Ohio State Neurosurgical Society**
OSU Upham Hall: Auditorium

9 - 10 AM **Tour of Exhibits**
Veterans Memorial

10 AM - 12 NOON **Ohio Ophthalmological Society Meeting**
Scioto Country Club, Columbus

11:30 AM **Luncheon, Section on Sports Medicine**
Sheraton: Baltic North, 2nd floor

12 NOON **OMPAC Luncheon and Speaker**
(11:30 AM Cash Bar)
Richard M. Scammon, Director of the Elections Research Center, Washington, D.C.
Tickets: $10 per person
Sheraton: Saturn & Jupiter, 2nd floor

12 NOON **Luncheon, Section on Neurosurgery and Ohio State Neurosurgical Society**
Sheraton: Harrison Room, 3rd floor

12 NOON **Luncheon, Ohio Ophthalmological Society**
Scioto Country Club, Columbus

12 NOON **Luncheon, Section on Otolaryngology and Ohio Society of Otolaryngology**
Sheraton: China-Malay, 2nd floor

(continued on page 236)

Annual Meeting Schedule *(continued)*

12 NOON — **Luncheon, Ohio Committee on Trauma**
Sheraton: Taft Room, 3rd floor

1:30 PM — **Ohio Committee on Trauma**
Sheraton: Auditorium

1:30 PM — **Ohio Health Commissioners Institute**
Veterans Memorial: Room 205

1:30 - 4:30 PM (All Day) — **Section on Otolaryngology and Ohio Society of Otolaryngology**
Veterans Memorial: Rooms 203-204

1:30 - 4:30 PM — **Section on Physical Medicine and Rehabilitation and Ohio Society of Physical Medicine and Rehabilitation**
Veterans Memorial: Room 102

1:30 - 5 PM (All Day) — **Section on Pathology and Ohio Society of Pathologists**
Veterans Memorial: Room 201

1 - 5 PM (All Day) — **Ohio Chapter, American College of Chest Physicians**
Veterans Memorial: Rooms 206-207

1 - 4:30 PM — **Ohio State Neurosurgical Society**
Veterans Memorial: Room 208

1:30 - 4:30 PM — **Advanced Life Support**
Veterans Memorial: South Terrace
(Continued Wednesday, May 18)

1:30 - 4:30 PM (All Day) — **Dermatology Course**
Sheraton: Venus Room, 2nd floor

1:30 - 5 PM — **Section on General Practice and Section on Sports Medicine**
Veterans Memorial: Assembly Hall

2 - 5 PM — **Section on Ophthalmology and Ohio Ophthalmological Society**
Veterans Memorial: Room 202

2:30 - 3 PM — **Tour of Exhibits**
Veterans Memorial

4:30 PM — **Close Exhibits for Tuesday**

6:30 PM — **OSMA Social Function**
Buddy Young Orchestra, Dinner and Dancing
$20 per person
Neil House

Wednesday, May 18

7:30 - 9:30 AM — **Five Postgraduate Courses**
(Continuation of Tuesday Courses—see Tuesday's Agenda)

7 AM — **Breakfast-Fifth District Caucus**
Sheraton: Grant Room, 3rd floor

8:30 AM — **General and Advance Registration Opens**
Veterans Memorial: Ground floor

9 AM — **All Exhibits Open**
Veterans Memorial

8:30 AM - 12 NOON — **Section on Allergy and Ohio Society of Allergy and Immunology**
Veterans Memorial: Rooms 206-207

9 AM — **Ohio Health Commissioners Institute**
Veterans Memorial: Room 205

9 - 10 AM — **Tour of Exhibits**
Veterans Memorial

9 AM - 12 NOON — **Section on Plastic Surgery**
Veterans Memorial: Room 202

9:30 AM - 12:30 PM — **Advanced Life Support**
Veterans Memorial: South Terrace
(Continued Wednesday afternoon)

12 NOON — **Luncheon, Section on Allergy and Ohio Society of Allergy and Immunology**
Sheraton: Taft Room, 3rd floor

12 NOON — **Luncheon, Section on Colon and Rectal Surgery**
Sheraton: Mediterranean-Caribbean, 2nd floor

12 NOON — **Luncheon, Section on Plastic Surgery**
Sheraton: China-Malay, 2nd floor

12 NOON — **Luncheon, Committee on Scientific Work**
Sheraton: Board Room, 21st floor

1:30 PM — **Ohio Health Commissioners Institute**

Veterans Memorial: Room 205

1:30 - 4:30 PM **Section on Anesthesiology and Ohio Society of Anesthesiologists, Inc.**
Veterans Memorial: Rooms 203-204

1:30 - 5 PM **Section on Colon and Rectal Surgery**
Veterans Memorial: Room 201

1:30 - 4:30 PM **Advanced Life Support**
Veterans Memorial: South Terrace

3 PM **All Exhibits Close**

2:30 - 3:30 PM **Registration of Delegates, Alternates, Council, and Official Guests for Final Session**
Sheraton: Terrestrial Promenade, 2nd floor

3:30 PM **Final Session-Business Meeting, OSMA House of Delegates**
Sheraton: Jupiter and Saturn, 2nd floor

6 PM **Buffet Dinner**
Delegates, Alternates, OSMA Council and Official Guests
Sheraton: Venus and Mars Rooms, 2nd floor

6:45 PM Continuation of **Final Session House of Delegates**
Sheraton: Jupiter and Saturn, 2nd floor

Annual Meeting Meal Functions

Luncheons, Monday, May 16

Section on Neurology: 12 NOON, Sheraton—China-Malay Rooms, 2nd floor.

Ohio Psychiatric Association: 12 NOON, Sheraton—Mediterranean-Caribbean Rooms, 2nd floor.

Section on Rheumatology: 12 NOON, Sheraton—Baltic North Room, 2nd floor.

Reception, Monday, May 16

All Exhibitors: 5 PM, Sheraton— Oceanic Suites, 2nd floor.

Breakfast, Tuesday, May 17

Association of County Medical Society Executives: 8 AM, Sheraton— Grant Room, 3rd floor.

(continued on page 238)



"You're The Doctor!"

Only you can take the proper safeguards that will provide an income in the event you're disabled. The OSMA co-sponsored **Disability Income Protection Plan** will assure you of as much as $500 in weekly benefits when disabled.

More protection for you, doctor:

The **O.S.M.A. Group Term Life Plan** offers coverage up to $100,000. 44% of last year's premium was returned as a dividend. (Dividends are not guaranteed.)

TURNER AND SHEPARD INC

17 South High Street Columbus, Ohio 43215 Phone (614) 228-6115
4015 Executive Park Drive Cincinnati, Ohio 45241 Phone (513) 563-4220
1900 Euclid Avenue Cleveland, Ohio 44115 Phone (216) 771-4747
3450 West Central Avenue Toledo, Ohio 43606 Phone (419) 535-0616

Meal Functions *(continued)*

OMPAC Board: 8 AM, Sheraton— Harrison Room, 3rd floor.

OMPAC: 11:30 AM (cash bar), 12 NOON Lunch, Sheraton— Saturn and Jupiter Rooms, 2nd floor.

Sports Medicine: 11:30 AM, Sheraton— Baltic-North Room, 2nd floor.

Ohio Ophthalmological Society: 12 NOON, Scioto Country Club, Columbus.

Otolaryngology: 12 NOON, Sheraton— China-Malay Rooms, 2nd floor.

Ohio Committee on Trauma: 12 NOON, Sheraton— Taft Room, 3rd floor.

Neurosurgery: 12 NOON, Sheraton— Harrison Room, 3rd floor.

Social Function, Tuesday, May 17

OSMA Social Function: Neil House Motor Inn Ballroom. Dinner and Dancing, $20 per person.

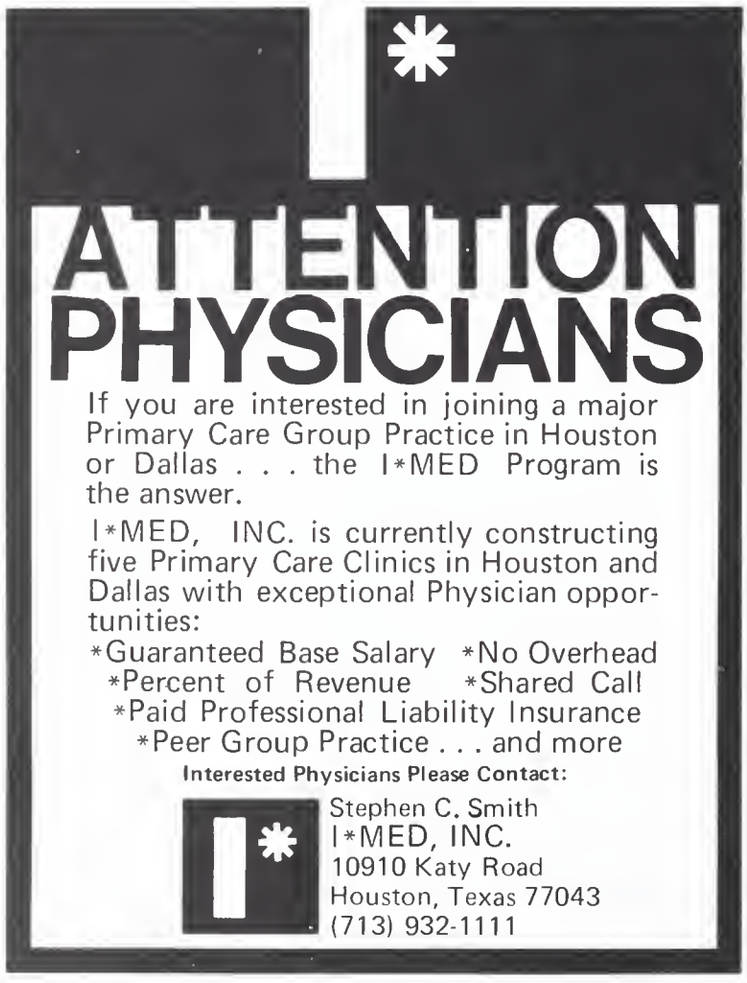
Luncheons, Wednesday, May 18

Allergy and Immunology: 12 NOON, Sheraton— Taft Room, 3rd floor.

Colon and Rectal Surgery: 12 NOON, Sheraton— Mediterranean-Caribbean Rooms, 2nd floor.

Section on Plastic Surgery: 12 NOON, Sheraton— China-Malay Rooms, 2nd floor.

Committee on Scientific Work: 12 NOON, Sheraton— Board Room, 21st floor.



OSMA Delegat

Sunday, May 15

3 - 7 PM — **Registration for OSMA House of Delegates**
Sheraton-Columbus Hotel: Terrestrial Promenade, 2nd floor

4 PM — **Councilor District Caucus Meetings**
Sheraton-Columbus Hotel: Locations to be posted at registration desk

5:30 PM — **Dinner for Delegates, Alternates, OSMA Council, and Official Guests**
Sheraton-Columbus Hotel: Mars and Venus Rooms, 2nd floor

7 PM — **Opening Session OSMA House of Delegates**
Sheraton-Columbus Hotel: Jupiter and Saturn Rooms, 2nd floor

BUSINESS AGENDA

Call to Order	George N. Bates, M.D., Toledo, OSMA President
Invocation	Donald J. Vincent, M.D., Columbus, Chairman, Committee on Medicine and Religion
Welcome	James W. Kilman, M.D., Columbus, President, Academy of Medicine of Columbus and Franklin County
Report	Committee on Credentials

Consideration of Minutes of 1976 Annual Meeting
(See July 1976 issue *The Ohio State Medical Journal.)*

Introduction of John H. Budd, M.D.,
Cleveland, AMA President-Elect

Introduction of John J. Coury, Jr., M.D.,
Port Huron, Michigan, AMA Trustee

Introduction of Honored Guests

Report	Joseph K. Gilmore, Columbus, President, Physicians Insurance Co. of Ohio
Report	Mrs. William Myers, Circleville, OSMA Auxiliary President
AMA-ERF Presentation	Philip B. Hardymon, M.D., Columbus, Chairman, Ohio Committee on AMA-ERF

Presentation of Plaques

nd Alternate Delegate Agenda

To past Councilors, retiring AMA Delegates and Alternates, Chairmen and Members of Standing Committees, and Chairmen of Special Committees.

Presentation of Life Memberships

Announcement George N. Bates, M.D., Toledo

Appointments to the Reference, Credentials, President's Address, Resolutions, and Tellers and Judges of Election Committees.

Elections of Committee on Nominations

Nominations from the floor. One representative (delegate) from each Council District. The committee shall report to the second and final session, Wednesday, May 18, 3:30 PM, its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Fourth District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the house of Delegates.

President's Address George N. Bates, M.D., Toledo

Introduction of Presidents of Other State Societies

Introduction of Resolutions

Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken.

Miscellaneous Business

Wednesday, May 18

2:30 PM **Registration for OSMA House of Delegates**
Sheraton-Columbus Hotel: Terrestrial Promenade, 2nd floor

3:30 PM **House of Delegates, Final Session**
Sheraton-Columbus Hotel: Jupiter and Saturn Rooms, 2nd floor

6 PM **Dinner for Delegates, Alternates, OSMA Council, and Official Guests**
Sheraton-Columbus Hotel: Mars & Venus rooms, 2nd floor

6:45 PM **Continuation of Final Session**
Sheraton-Columbus Hotel: Jupiter & Saturn Rooms, 2nd floor

BUSINESS AGENDA

Introduction of Guests

Presentation of Journalism Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Nominations for The Council

Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in odd-numbers years.

Second District: Incumbent, W.J. Lewis, M.D., Dayton; Fourth District: Incumbent, C. Douglas Ford, M.D., Toledo; Sixth District: Incumbent, C. Edward Pichette, M.D., Youngstown; Eighth District: Incumbent, Richard E. Hartle, M.D., Lancaster; Tenth District: Incumbent, J. Hutchison Williams, M.D., Columbus; Twelfth District: Incumbent, William Dorner, Jr., M.D., Akron.

Election of Councilor to fill unexpired term, District 1, under provisions of Section 7, Chapter 7 of the Bylaws.

Election of Delegates and Alternates to the AMA

Five Delegates and five Alternates to be elected for a two-year term starting January 1, 1978, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1977, their terms expiring December 31, 1977.

Delegates (listed alphabetically): Oscar W. Clarke, M.D., Gallipolis; Henry A. Crawford, M.D., Cleveland; Harry K. Hines, M.D., Cincinnati; W.J. Lewis, M.D., Dayton; P. John Robechek, M.D., Cleveland.

Alternates (listed alphabetically): George N. Bates, M.D., Toledo; Theodore J. Castele, M.D., Cleveland; Richard L. Fulton, M.D., Columbus; John J. Gaughan, M.D., Cleveland; William J. Schrimpf, M.D., Cincinnati.

All nominees for the offices of AMA Delegates and AMA Alternates shall run at large. Election of Delegates and Alternates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

Reports of Reference Committees

President's Address; Resolutions Committee No. 1; Resolutions Committee No. 2; Resolutions Committee No. 3.

Miscellaneous Business

Installation of Officers for 1977-1978

Announcement William M. Wells, M.D., Newark
OSMA President

Appointments on Standing Committees and action thereon by the House of Delegates.

Unfinished business

Adjournment

Members of 1977 House of Delegates

By County: Delegates left column, Alternate Delegates right column.

First District

ADAMS COUNTY
William J. Lundy — Francis Stevens

BROWN COUNTY
John R. Donohoo — Gene F. Conway

BUTLER COUNTY
Edwin L. Helfman — James P. Baden
James M. Smith — Marvin J. Rassell

CLERMONT COUNTY
Carl A. Minning — William B. Selnick

CLINTON COUNTY
Foster J. Boyd

HAMILTON COUNTY
John E. Albers — Frederick Brockmeier
Eugene J. Burns — Neal N. Earley
Edmund C. Casey — Harry H. Fox
Stewart B. Dunsker — Robert J. Hasl
Charles D. Feuss, Jr. — James L. Leonard
George D. J. Griffin — H. Glenn Overley
Robert S. Heidt — Walter B. Rugh, Jr.
Harry K. Hines
Stephen P. Hogg
Stanley J. Lucas
Glenn W. Pfister, Jr.
William J. Schrimpf
Andrew J. Weiss

HIGHLAND COUNTY
Glenn B. Doan

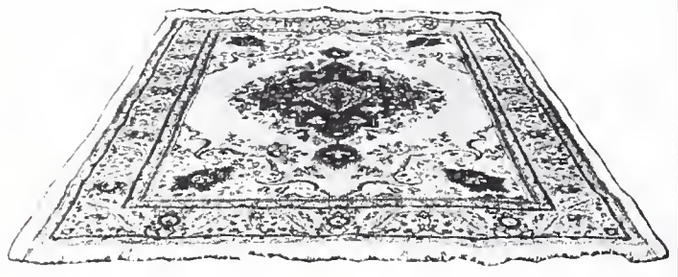
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WARREN COUNTY
Thomas E. Fox — George Van Harlingen

Second District

CHAMPAIGN COUNTY
Isador Miller — John H. Flora

CLARK COUNTY
Henry Diederichs — William Allison
Ernest Winterhoff — William Harper

DARKE COUNTY
Jesse L. Heise — Jose R. Solis

GREENE COUNTY
Roger C. Henderson — Paul C. Vernier

MIAMI COUNTY
A. Robert Davies — Jerry Hammon

MONTGOMERY COUNTY
R. Alan Baker — D. Kiefer Campbell
John H. Boyles, Jr. — Robert K. Finley, Jr.
W. J. Lewis — Gilbert W. Hopkins
John H. Taylor — Richard G. Jenkins
John R. Whitaker, Jr. — Frederic C. Schnebly

PREBLE COUNTY
Chester J. Brian — Birna R. Smith

SHELBY COUNTY
George Schroer

Third District

ALLEN COUNTY
David Barr — Thomas Leech
Joseph Oppenheim — Gene E. Wright

AUGLAIZE COUNTY
David W. Nielsen — Elizabeth Kuffner

HANCOCK COUNTY
William Kose — Edwin Davis

HARDIN COUNTY
Leonard K. Smith — Robert B. Elliott

LOGAN COUNTY
James Steiner

MARION COUNTY
Paul E. Lyon — D. Lee Johnson

MERCER COUNTY
James Otis — Donald Fox

SENECA COUNTY
James A. Murray — Walter Daniel

WYANDOT COUNTY
Konstantine K. Solacoff — Joseph J. Browne

Fourth District

DEFIANCE COUNTY
Ben Lenhart — Robert J. Foldvary

FULTON COUNTY
Benjamin H. Reed, Jr. — Vernon Cotterman

HENRY COUNTY
Robert J. Blough — Reynaldo C. Soriano

LUCAS COUNTY
John A. Devany — Ernest Brookfield
Roland A. Gandy, Jr. — Mary Ellen Clifford
B. Leslie Huffman, Jr. — Frank E. Foss
M. Brodie James — Robert L. Hauman
Thomas J. O'Grady — Leo J. Miedler
Peter A. Overstreet — Burchard E. Winne
Harry L. Snyder — Richard J. Wiseley

OTTAWA COUNTY
John F. Bodie — V. William Wagner

PAULDING COUNTY
Doyt E. Farling — Don K. Snyder

PUTNAM COUNTY
James B. Overmier — John R. Brown

SANDUSKY COUNTY
Samuel Lowery — Willis Damschroder

WILLIAMS COUNTY
Robert W. Dilworth — John E. Moats

WOOD COUNTY
Douglas S. Hess — Albert Smith

Fifth District

ASHTABULA COUNTY
Harold C. Franley — Shepard A. Burroughs

CUYAHOGA COUNTY
Donavin A. Baumgartner, Jr. — Matthew R. Biscotti
Edward J. Bishop — Roland D. Carlson
Charles L. Cassady — Matthew W. Collings
Theodore J. Castele — Gilbert Derian
Henry A. Crawford — Edwin H. Eigner
Nicholas G. DePiero — Richard B. Fratianne
Clarence L. Huggins, Jr. — Roscoe J. Kennedy
Edward G. Kilroy — Robert C. Kirk
Steven Kovacs — John A. Kmieck
Vincent T. La Maida — Leroy W. Matthews
George P. Leicht — Valentin F. Mersol
Leonard L. Lovshin — Russell J. Nicholl
Lawrence J. McCormack — George W. Petznick
Richard J. Nowak — Walter J. Pories
Thomas P. Paras — Casimer F. Radkowski
John G. Poulos — Joseph Schultz
P. John Robechek — Warner W. Tuckerman
A. Benedict Schneider
Howard S. Siegel
Franklyn J. Simecek
Frederick T. Suppes
Howard S. Van Ordstrand

Crawford, Vinton, and Van Wert Counties had not reported the names of their delegates as of press time.

GEAUGA COUNTY
Bruce Andreas — Arturo Dimaculangan

LAKE COUNTY
John A. Bukovnik — Harry A. Killian
Wesley J. Pignolet — Carl G. Madsen, Jr.

Sixth District

COLUMBIANA COUNTY
William Banfield — Leonard S. Pritchard

MAHONING COUNTY
J. James Anderson — Rashid Abdu
John C. Melnick — George H. Deitz
C. Edward Pichette — William E. Sovik
Jack Schreiber — Joseph W. Tandatnick

STARK COUNTY
Edward J. Davis — Henry H. Clapper
Edward E. Grable — Mark G. Herbst
Raymond J. McMahon, Jr. — Robert C. Reed
Joseph Yut — Walter J. Telesz

TRUMBULL COUNTY
Joseph L. Logan — Harold L. Brodell
Joseph Sudimack, Jr. — William Gross

Seventh District

BELMONT COUNTY
Azad Katchian — Lois Zimmerman

CARROLL COUNTY
Carl A. Lincke — Thomas J. Atchison

COSHOCTON COUNTY
Norman L. Wright — Robert R. Johnson

HARRISON COUNTY
Elias Freeman — Janis Trupovnieks

JEFFERSON COUNTY
Irving Dreyer — Augusto P. Fojas

MONROE COUNTY
Donald R. Piatt — Joseph W. Blevins

TUSCARAWAS COUNTY
Philip T. Doughten — Benjamin J. Wherley

Eighth District

ATHENS COUNTY
John F. Kroner — Bruce Paxton

FAIRFIELD COUNTY
James A. Merk — David H. Sheidler

GUERNSEY COUNTY
Robert A. Ringer — William S. Quigley

LICKING COUNTY
John P. Anderson — Carl M. Frye

MORGAN COUNTY
Austin A. Coulson — Henry Bachman

(continued on page 242)

Delegates *(continued)*

MUSKINGUM COUNTY
Carl Spragg — Benjamin Gilliotte

NOBLE COUNTY
Edward G. Ditch — Frederick M. Cox

PERRY COUNTY
Sidney Lord — Alfredo Cruz

WASHINGTON COUNTY
Gregory B. Krivchenia — Kenneth E. Bennett

Ninth District

GALLIA COUNTY
Thomas P. Price, Jr. — Edward J. Berkich

HOCKING COUNTY
Lethia W. Starr — Jan Matthews

JACKSON COUNTY
John Zimmerly — Carl J. Greever

LAWRENCE COUNTY
Burton Payne — Harry Nenni

MEIGS COUNTY
Roger P. Daniels — Raymond E. Boice

PIKE COUNTY
Albert Shrader — Horace Giffen

SCIOTO COUNTY
Chester H. Allen — Carter L. Pitcher

Tenth District

DELAWARE COUNTY
David R. Smith, Jr. — Adelbert R. Callander

FAYETTE COUNTY
Robert A. Heiny — Marvin H. Roszmann

FRANKLIN COUNTY

Homer A. Anderson	Ben Arnoff
Michael A. Anthony	James E. Barnes
Robert C. Atkinson	Janet K. Bixel
Joseph A. Bonta	William C. Earl
Walter M. Haynes, Jr.	H. Gene Ewy
George W. Paulson	Richard L. Fulton
H. William Porterfield	Frederick M. Kapetansky
Jack E. Tetirick	William A. Millhon
J. Hutchison Williams	Alexander Pollack

KNOX COUNTY
Henry T. Lapp — Roger Sherman

MADISON COUNTY
Sol Maggied — J. Richard Hurt

MORROW COUNTY
David J. Hickson — William S. Deffinger

PICKAWAY COUNTY
Robert G. Smith — Ray Carroll

ROSS COUNTY
Joseph McKell — Lewis Coppel

UNION COUNTY
Lawrence A. Gould — Walter R. Burt

Eleventh District

ASHLAND COUNTY
Jon Cooperrider — Charles H. Warne

ERIE COUNTY
Howard Smith — Robert Sawicki

HOLMES COUNTY
Luther W. High — Maurice Mullet

HURON COUNTY
Nino M. Camardese — Earl R. McLoney

LORAIN COUNTY

John Bartone	Henry E. Kleinhenz
Delbert L. Fischer	Andrew Mattey
Thomas Sfiligoj	Raymundo de la Pena

MEDINA COUNTY
Richard W. Avery — Rolland L. Mansell

RICHLAND COUNTY

Harold F. Mills	James F. Clements
James W. Wiggin	Donald E. Mills

WAYNE COUNTY
A. Burney Huff — John M. Robinson

Twelfth District

PORTAGE COUNTY
F. Michael Sheehan — John Fulton

SUMMIT COUNTY

Rocco M. Antenucci	Francis A. Cleary
Roy E. Bugay	Charles A. East
Robert R. Clark	James G. Roberts
Douglas M. Evans	Fred F. Somma
Manley L. Ford	
W. Paul Kilway	
Joseph L. Kloss	

OSMA OFFICERS

President ..... George N. Bates
President-Elect ..... William M. Wells
Past President ..... Maurice F. Lieber
Secretary-Treasurer ..... Robert G. Thomas

OSMA COUNCILORS

First District ..... Stephen P. Hogg
Second District ..... W. J. Lewis
Third District ..... Alford C. Diller
Fourth District ..... C. Douglass Ford
Fifth District ..... John J. Gaughan
Sixth District ..... C. Edward Pichette
Seventh District ..... Robert E. Rinderknecht
Eighth District ..... Richard E. Hartle
Ninth District ..... Thomas W. Morgan
Tenth District ..... J. Hutchison Williams
Eleventh District ..... S. Baird Pfahl, Jr.
Twelfth District ..... William Dorner, Jr.

Annual Meeting Postgraduate Courses

Category I continuing medical education courses will be offered at the 1977 OSMA Annual Meeting. The following courses have been designed by the OSMA Committee on Scientific Work. Participants in each course will receive four Category I hours which may be applied toward the OSMA and the AMA Physician's Recognition Awards and the Ohio State Medical Board's Relicensure Program.

The courses will be held in two parts on Tuesday, May 17, and Wednesday, May 18, from 7:30 to 9:30 AM at the Sheraton-Columbus Hotel. The $20 registration fee per course includes a continental breakfast each morning. Registration is limited, so early registration is urged. Use the form on the following page to indicate your course choice.

COURSE ONE: *Clinical Management of Electrolyte and Acid-Base Disturbances* — Tuesday: "Clinical Management of Electrolyte Imbalance," Wednesday: "Clinical Management of Acid-Base Disturbances"

Course Director: William H. Bay, M.D., Assistant Professor, Ohio State University College of Medicine

Course Synopsis: "Clinical Management of Electrolyte Imbalance" will deal with the diagnosis and management of patients with hyper- and hyponatremia and hyper- and hypokalemia. A simplified approach to diagnosis will be presented and the treatment will be discussed. Case presentations to stimulate discussions are planned.

"Clinical Management of Acid-Base Disturbances" will stress a diagnostic approach to divide acid-base abnormalities into four categories: respiratory acidosis and alkalosis, and metabolic acidosis and alkalosis. Appropriate therapy for these problems will be reviewed. Case presentations to stimulate discussion are planned.

Enrollment: Limited to 35

COURSE TWO: *Neurology Revisited*

Course Director: George Paulson, M.D., Clinical Professor of Neurology, Ohio State University College of Medicine

Course Synopsis: This is a reintroduction to select aspects of neurology of importance to practitioners. The first hour will include instruction in the neurological examination in adults and children. The second hour will include discussion of concepts of movement disorders, demyelinating diseases, migraine and related disorders, and newer drugs used in seizure disorders. The third hour will discuss neurological and neurosurgical emergencies and iatrogenic diseases of the nervous system. The last hour will discuss vascular and degenerative diseases and diseases caused by the environment. Each session is to emphasize current concepts and therapy, and questions are to be allowed at the completion of each session. A syllabus will be supplied, as well as reference sources.

Enrollment: Limited to 35

COURSE THREE: *The Laboratory — How It Can Help Your Practice*

Course Director: Thomas D. Stevenson, M.D., Professor of Pathology, Ohio State University College of Medicine

Course Synopsis: The purpose of this course is to provide the practitioner with examples of how the laboratory can aid in solving clinical problems. Problems in laboratory diagnosis will be presented, including hematology, urinalysis, and blood chemistry.

Enrollment: Limited to 35

COURSE FOUR: *Sound Prescription of* Common *Drugs*

Course Director: John Lindower, M.D., Professor and Chairman of Pharmacology, Assistant Dean for Curricular Affairs, Wright State University School of Medicine, Dayton

Course Synopsis: The rational use of medication is based upon a practical understanding of useful and ill effects of drugs. In addition to knowing how people respond to drugs, the doctor who understands how patients "handle" model drugs will give excellent care. The goal of this course is the practical pharmacological consideration of some commonly prescribed drugs. A series of brief presentations will be mixed with concise practical questions and consequent discussion.

Enrollment: Limited to 35

COURSE FIVE: *Basic Pulmonary Physiology*

Course Director: Roy L. Donnerberg, M.D., Associate Professor, Pulmonary Disease Division, Department of Medicine, Ohio State University College of Medicine

Course Synopsis: The course will essentially consist of reviewing the material in the book *Respiratory Physiology — The Essentials* by Dr. John B. West. This book will be provided by the Ohio State Medical Association. The material will be covered primarily chapter by chapter, although it may not be taken in exact sequence and some chapters may not be discussed. The last hour of the course will involve a review of pulmonary physiology and the application of it to common types of pulmonary disease seen today in practice.

Enrollment: Limited to 25

(See following page for registration form.)

Richard M. Scammon To Speak at OMPAC Luncheon

Tuesday, May 17, Sheraton-Columbus

The Ohio Medical Political Action Committee (OMPAC) speaker at the 1977 OSMA Annual Meeting will be Richard M. Scammon. Since 1955, Mr. Scammon has been Director of the Elections Research Center located in Washington, D.C. Mr. Scammon, who has been the OMPAC speaker in previous years, will deliver his address at a noon luncheon on Tuesday, May 17. Tickets are $10 per person and may be reserved by returning the form at the bottom of this page, along with a check in the correct amount.



A native of Minneapolis, Richard Scammon was educated at the Universities of Minnesota and Michigan and at the London School of Economics. He served as Research Secretary for the University of Chicago's "NBC Round Table" radio broadcasts from 1939 to 1941. In 1941, Mr. Scammon entered the United States Army and served in both the United States and Western Europe until 1946. At that time, he became a military government officer in Stuttgart and Berlin, Germany. In 1948, Mr. Scammon returned to the U.S. as Chief, Division of Research for Western Europe, United States Department of State.

Since becoming Director of the Elections Research Center in 1955, Mr. Scammon has also functioned in a number of other roles. In 1958, he was chairman of the U.S. delegation that observed elections in Russia. From 1961 to 1965, Mr. Scammon took a leave of absence from the Elections Research Center to serve as the director of the U.S. Bureau of the Census. During this time, he also was Chairman of the President's Commission on Registration and Voting Participation. In 1973, he was a member of the U.S. Delegation to the General Assembly of the United Nations.

Other roles include: United States member of the Organization of American States Technical Electoral Mission to the Dominican Republic, 1966; chairman of the U.S. Select Commission on the Western Hemisphere Immigration, 1966-1968; president of the National Council on Public Polls, 1969-1970, and trustee of that organization since 1970; and member of the President's Commission on Federal Statistics, 1970-1971.

Additionally, Mr. Scammon is vice president of the American Immigration and Citizenship Conference; a member of the board of directors of the American Arbitration Association; an elections consultant for NBC News; a sometimes professorial lecturer at Howard, Johns Hopkins, George Washington, and York (Ontario) Universities, and a Fellow of the American Statistical Association. He is the editor of *America . . . At the Polls* (1965); *This U.S.A.* (1965); *The Real Majority* (1970); and *America Votes*, Volumes 1 through 11 (1956-1975). Mr. Scammon is listed in *Who's Who in America*.

Annual Meeting Courses, OMPAC Luncheon, and Social Function

REGISTRATION FORM

Please register me for the following Annual Meeting activities:

☐ Postgraduate courses, May 17 & 18: — Fee: $20

1st Choice: Course No._____

2nd Choice: Course No._____

3rd Choice: Course No._____

☐ Dermatology for the Non-Dermatologist, May 17 — Fee: $75

☐ Ethical Dilemma of Crisis Medicine, May 14 — Fee: None

☐ Negotiating, May 14 & 15 — Fee: $125 OSMA Members, $175 Non-Members

☐ Public Speaking, May 14 & 15 — Fee: $130 OSMA Member, $145 Non-Members

☐ OMPAC Luncheon, May 17 — Fee: $10 per person

☐ Social Function, May 17 — Fee: $20 per person

Total:_____

Make Checks payable to: Ohio State Medical Association

NAME_____
(Please Print)

ADDRESS_____
(Street) (City) (State) (Zip)

I am
☐ OSMA Member
☐ Non-member Physician
☐ Other_____
☐ Medical Student
☐ Guest
☐ Please prepare guest badge for my spouse.

Mail form to:
Department of Continuing Medical Education, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215

The Ohio State Medical Association New Members

ALLEN (Lima)
Frank M. Baldauf
Byong Cho Kim
Pricha Luengchavapongs
Thomas G. Oyer

CARROL (Carrollton)
Nan M. Bissell

CRAWFORD (Crestline)
Chi Hong Yang

DEFIANCE (Defiance)
Anthony E. Foley

ERIE (Sandusky)
John Y. Lee

FAYETTE (Washington Court House)
Chau Chi Lin

FRANKLIN (Columbus unless noted)
Rosalind J. Bobulski, Westerville
Stewart P. Chase
Irineo P. Pantangco

GUERNSEY (Cambridge)
Hugo Ramirez
Andres M. Tinana

HANCOCK (Findlay)
Kek Tiong Ang
Robert D. Beck
Richard H. Deerhake
Domingo S. Uy

KNOX (Mt. Vernon)
Robert Rodstrom

LAWRENCE (Ironton)
James B. Zimmerman

LORAIN (Elyria unless noted)
M. V. Gopinath
Ramiz Masri
Stephen M. Ticich, Lorain

MAHONING (Youngstown)
John N. Brucoli
Anand G. Garg
George F. Hromyak, Jr.
Gerald Klebanoff
James M. Kline
Chi-Sown Ko
David E. Pichette
Fred R. Pruitt

MARION (Mt. Sterling)
Leung-Bun Wong

MONTGOMERY (Dayton)
Richard C. Cammerer
Hernan A. Campana
Carrol H. Estep
Deepak Kumar
Homayoung Mesghali
Bassam Nakfour
Talmage N. Porter

MUSKINGUM (Zanesville)
Myron F. Knell, Jr.
John E. Van Gilder

ROSS (Chillicothe)
Robert E. Kell

SHELBY (Sidney unless noted)
Yung Ju Kee
Robert J. Miller
M. David Rhee
Joseph Steurnagel, Ft Loramie

Editor's Note: *The Ohio State Medical Association officers and councilors urge all association members to make plans to attend the 1977 Annual Meeting, May 14-18 in Columbus. Details of the Annual Meeting activities appear in this and the March 1977 issues of* The Journal.—*L.A.J.*

FIRST FACIAL NERVE SYMPOSIUM IN THE UNITED STATES
JUNE 19-23, 1977 HILTON HOTEL, PITTSBURGH
Co-Chairmen: Donald B. Kamerer, M.D. and Mark May, M.D.
The Division of Continuing Education and Department of Otolaryngology
University of Pittsburgh School of Medicine
The American Academy of Ophthalmology and Otolaryngology Facial Nerve Study Group
GREAT NAMES: Irving Blatt . . John J. Conley . . Ugo Fisch . . Michael E. Glasscock . . Peter Jannetta . . G. W. Kreutzberg . . Frank Lathrop . . Brian F. McCabe . . Adolph Miehlke . . Hanno Millesi . . Jack Pulec . . Jacob Sade . . James W. Smith . . Sidney Sunderland . . G. Valvassori
KEY SUBJECTS: Total Approach to Facial Paralysis — D_X, P_X, R_X . . Electrical and Non-Electrical Testing . . D_X and R_X of Congenital, Infection, Trauma, Tumors . . Intracranial, Intratemporal, Extracranial Surgery . . Treatment of Bell's Palsy . . Management of Facial Hyperkinesis . . New Concepts in Facial Rehabilitation . . Grafting Techniques . . Management of Complications . . Medical Legal Aspects . . Psychiatric Aspects
CONTINUING EDUCATION CREDITS: This Program meets the criteria for 23 hours of credit in Category One for the Physician's Recognition Award of the American Medical Association.
For further information contact: Division of Continuing Education
1022-H Scaife Hall
University of Pittsburgh School of Medicine
Pittsburgh, PA 15261
(412) 624-2653



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County Society Officers, Executive Directors, and Meeting Dates

First District

Councilor: *Stephen P. Hogg, M.D.,* 250 Wm. Howard Taft Rd., Cincinnati 45219.

ADAMS: William J. Lundy M.D., President, 522 E. Main St., West Union 45693; Francis Stevens, M.D., Secretary, 845 E. Walnut St., West Union 45693. Second Tuesday.

BROWN: Philip Pfalzgraf, M.D., President, 1830 Ohio Pike, R.D. 1, Batavia 45103; Gene F. Conway, M.D., Secretary-Treasurer, 315 E. State Street, Georgetown 45121. First or Second Sunday.

***BUTLER:** H. Sheffield Jeck, M.D., President, 5995 Fairfield Rd., Oxford 45056; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., Hamilton 45011, (513) 893-1410. Fourth Wednesday, October-May except December.

CLERMONT: Donald K. Ebersold, M.D., President, 819 Forest Avenue, Milford 45150; William Blake Selnick, D.O., Secretary, Second & E. Loveland Ave., Loveland 45140. Third Wednesday.

CLINTON: Richard R. Buchanan, M.D., President, 115 W. Main St., Wilmington 45177; H. Chung Tai Hu, M.D., Secretary, 168 W. Main St., Wilmington 45177.

***HAMILTON:** Stanley J. Lucas, M.D., President, 2905 Burnet Ave., Cincinnati 45219; John H. Wulsin, M.D., Secretary, Cincinnati General Hospital, Cincinnati 45229; William J. Galligan, Executive Secretary, 320 Broadway, Cincinnati 45202, (513) 721-2345. Second Tuesday except August.

HIGHLAND: Glenn B. Doan, M.D., President, 528 South Street, Greenfield 45123; Walter Felson, M.D., Secretary-Treasurer, 357 South Street, Greenfield 45123.

WARREN: George Van Harlingen, M.D., President, 4 Oakwood Avenue, Lebanon 45036; Raymond Simeninger, M.D., Secretary, 901 North Broadway, Lebanon 45036. Second Tuesday.

Second District

Councilor: *W. J. Lewis, M.D.,* 2567 Far Hills Ave., Dayton 45419.

CHAMPAIGN: John H. Flora, M.D., President, 848 Scioto Street, Urbana 43078; Barry Paxton, M.D., Secretary-Treasurer, 900 Scioto Street, Urbana 43078. Second or Third Wednesday.

CLARK: Harry M. Berley, M.D., President, 1425 Xenia Avenue, Yellow Springs 45387; James Gianakopoulos, M.D., Secretary, 34 W. High St., Springfield 45502; Dalia Remys, Executive Secretary, 1002 N. Fountain Avenue, Springfield 45504, (513) 324-8618. Third Monday except June, July, and August.

DARKE: Gregory M. Weber, M.D., President, 552 S. West St., Versailles 45380; Santos T. Tividad, M.D., Secretary, 1096 E. Evergreen Dr., Greenville 45331. Third Tuesday.

GREENE: Ray W. Barry, M.D., President, 1450 Hanes Rd., Xenia 45385; Larry Clark, M.D., Secretary-Treasurer, 1450 Hanes Rd., Xenia 45385; Mrs. Virginia Jones, Executive Secretary, 1003 Parnell Dr., Xenia 45385, (513) 372-8011, Ext. 287.

MIAMI: Joseph J. Trevino, M.D., President, 113 Castle Dr., Piqua 45356; Richard H. Burk, M.D., Secretary, 550 Summit Ave., Suite #6, Troy 45373. First Tuesday.

MONTGOMERY: Don E. Sando, M.D., President, 60 Wyoming St., Dayton 45409; George P. Sperry, M.D., Secretary, 229 E. Stroop Rd., Dayton 45429; Earl E. Shelton, Executive Director, 280 Fidelity Med. Bldg., Dayton 45402, (513) 223-3185. Fourth Thursday except July, August, and December.

PREBLE: John D. Darrow, M.D., President, 101 Edgewood Dr., Eaton 45320; Joseph R. Williams, M.D., Secretary-Treasurer, Hillcrest Dr., Eaton 45320.

SHELBY: George Schroer, M.D., President, 20 S. Main, Ft. Loramie 45845; Edward Link, M.D., Secretary-Treasurer, Third & Michigan, Sidney 45365. Third Tuesday—quarterly.

Third District

Councilor: *Alford C. Diller, M.D.,* Medical Arts Bldg., Fox Road, Van Wert 45891.

***ALLEN:** Fred Rohdes, M.D., President, 825 W. Market, Lima 45801; William T. Collins, M.D., Secretary-Treasurer, Lima Memorial Hospital, Lima 45804; Mr. Will Wolf, Executive Secretary, Box 1647, Lima 45802, (419) 228-1105. Third Tuesday, September through May.

AUGLAIZE: Charles D. Stienecker, M.D., President, 1007 W. Auglaize Street, Wapakoneta 45895; James R. Romaker, M.D., Secretary-Treasurer, 114 W. Main, Lima 45806. First Thursday—January, March, May, September, and November.

CRAWFORD: Mehdi M. Ressallat, M.D., President, 124 S. Market St., Galion 44833; Donald E. Widman, M.D., Secretary-Treasurer, Galion Community Hospital, Galion 44833.

HANCOCK: Edwin Davis, M.D., President, 1119 N. Main St., Findlay 45840; Herbert A. Mahler, M.D., Secretary, 117 E. Wallace, Findlay 45840. Third Tuesday.

HARDIN: Robert A. Thomas, M.D., President, 215 N. Main, Mt. Victory 43340; Richard O. Pelham, M.D., Secretary-Treasurer, R.R. #1, Pamela Dr., Kenton 43326. Second Tuesday.

(continued on page 248)

* These counties change officers between May and September.

County Society Officers *(continued)*

LOGAN: Allen J. Stuckey, M.D., President, Rt. #2, West Liberty 43357; Grant K. Varian, M.D., Secretary, 1008 N. Main St., Bellefontaine 43311. Five meetings per year, generally January, March, May, September, and November.

MARION: Robert T. McKinlay, M.D., President, 1130 Independence Ave., Marion, Ohio 43302; Pavanender Gupta, M.D., Secretary-Treasurer, Marion General Hospital, McKinley Park Dr., Marion 43302. First Tuesday except June, July, and August.

MERCER: Emiliano Feliciano, M.D., President, 161 S. Walnut St., St. Henry 45883; Donald R. Fox, M.D., Secretary-Treasurer, 118 W. Fulton St., Celina 45822. Third Thursday.

SENECA: Rosario D. Bello, M.D., President, 430 Elm St., Fostoria 44830; George J. Padanilam, M.D., Secretary-Treasurer, 504 Van Buren St., Fostoria 44830. Third Tuesday, except July and August.

VAN WERT: Wilmer Iler, M.D., President, Medical Arts Bldg., Fox Rd., Van Wert 45891; Donald Hughes, M.D., Secretary-Treasurer, Van Wert County Hospital, Van Wert 45891.

WYANDOT: K. K. Solacoff, M.D., President, 777 N. Sandusky Ave., Upper Sandusky 43351; J. J. Browne, M.D., Secretary-Treasurer, 777 N. Sandusky Ave., Upper Sandusky 43351. Second Tuesday.

Fourth District

Councilor: *C. Douglass Ford, M.D.,* 2361 W. Bancroft St., Toledo 43607.

DEFIANCE: Homer C. Brown, M.D., President, 1132 E. Second St., Defiance 43512; Subash Mathew, M.D., Secretary-Treasurer, Defiance Clinic, 1400 E. Second St., Defiance 43512.

FULTON: Robert S. Jessup, M.D., President, 844 S. Shoop St., Wauseon 43567; Gerald A. Perkins, D.O., Secretary-Treasurer, R. #1, Box 20-A, Delta 43515. Quarterly.

HENRY: Thomas F. Moriarty, M.D., President, 651 Strong St., Napoleon 43545; K. E. Dye, D.O., Secretary-Treasurer, Box 5, Liberty Center 43532. First Tuesday.

LUCAS: Walter H. Hartung, Jr., M.D., President, St. Charles Hospital, 2600 Navarre Ave., Toledo 43616; Frank E. Foss, M.D., Secretary, St. Vincent Hospital, 2213 Cherry St., Toledo 43608; Lee F. Wealton, Executive Director, Secor Professional Bldg., 4428 Secor Rd., Toledo 43623, (419) 473-3200. Fourth Tuesday.

OTTAWA: V. William Wagner, M.D., President, 105 Madison St., Port Clinton 43452; Robert S. Reeves, M.D., Secretary-Treasurer, 504 E. Water St., Oak Harbor 43449. Second Thursday.

PAULDING: Don K. Snyder, M.D., President, Rt. 2, Paulding 45879; Kirkwood A. Pritchard, M.D., Secretary-Treasurer, 119 S. Main St., Paulding 45879. Third Monday.

PUTNAM: John R. Brown, M.D., President, 310 E. Main, Ottawa 45875; Earl D. DeWitt, M.D., Secretary-Treasurer, P.O. Box 148, Columbus Grove 45830. First Tuesday.

SANDUSKY: Willis Damschroder, M.D., President, 116 N. Main, Gibsonburg 43431; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420, (419) 332-7321 Quarterly.

WILLIAMS: Virgil N. Carrico, M.D., President, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506; Richard L. Hess, M.D., Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506; Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, (419) 636-4517. Third Tuesday— January, March, May, September, and November.

WOOD: William F. Lord, M.D., President, Wood County Hospital, Bowling Green 43402; Manuel L. de la Serna, Jr., M.D., Secretary-Treasurer, 640 S. Wintergarden Rd., Bowling Green 43402. Third Tuesday.

Fifth District

Councilor: *John J. Gaughan, M.D.,* 7911 Detroit Ave., Cleveland 44102.

ASHTABULA: M. Meshginpoosh, M.D., President, 254 S. Broadway, Geneva 44041; Robert L. McTrusty, M.D., Secretary, 2709 Lake Ave., Ashtabula 44004; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, (216) 998-3111. Second Tuesday.

***CUYAHOGA:** George P. Leicht, M.D., President, 25300 Lorain Ave., North Olmsted 44070; Steven Kovacs, M.D., Secretary-Treasurer, 17811 Lake Rd., Cleveland 44107; Robert A. Lang, Ph.D., Executive Director, 10525 Carnegie Ave., Cleveland 44106, (216) 231-3500.

GEAUGA: W. T. Pien, M.D., President, 16022 E. High St., Middlefield 44062; William Reed, M.D., Secretary-Treasurer, 14577 E. Park St., Burton 44021; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, (216) 286-3961. Second Tuesday except July and August.

LAKE: R. J. Taddeo, M.D., President, 36001 Euclid Ave., Willoughby 44094; Roger W. Sherman, M.D., Secretary, 8224 Mentor Ave., Mentor 44060; Mrs. Marge McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060, (216) 255-2233. Feb. 22, May 25, Sept. 27, and Nov. 15.

Sixth District

Councilor: *C. Edward Pichette, M.D.,* 1010 Boardman-Canfield Rd., Youngstown 44512.

COLUMBIANA: Francisco Avellana, M.D., President, 700 Main St., Wellsville 43968; Rolland E. Herron, M.D., Secretary-Treasurer, 816 N. Lincoln Ave., Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, (216) 337-8859. Third Tuesday.

MAHONING: J. James Anderson, M.D., President, 5204 Mahoning Ave., Youngstown 44515; A. T. Deramo, M.D., Secretary, 5701 Market St., Youngstown 44512;

Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, (216) 747-4956. Third Tuesday—January, March, May, September, November, and December.

STARK: Brian S. Harrold, M.D., President, 1341 Market N., Canton 44714; Willard J. Howland, M.D., Secretary-Treasurer, Aultman Hospital, Canton 44710; Raymond T. Sullivan, Jr., Executive Secretary, Stark County Medical Society, Suite #513, 315 W. Tuscarawas St., Canton 44702, (216) 454-2400. Council—First Thursday. General— Second Thursday.

TRUMBULL: Robert Paul, M.D., President, Trumbull Memorial Hospital, 1938 E. Market St., Warren 44483; Richard Shapiro, M.D., Secretary-Treasurer, 3893 E. Market St., Warren 44484; Teresa Bastista, Executive Secretary, P.O. Box 1328, Warren 44482, (216) 394-4556. Third Wednesday.

Seventh District

Councilor: *Robert E. Rinderknecht, M.D.,* 404 N. Walnut St., Dover 44622.

BELMONT: Azad Katchian, M.D., President, Rt. #2, Harrisville Clinic, Adena 43901; Nermin D. Lavapies, M.D., Secretary, 1220 Hughes Ave., Martins Ferry 43935. Third Thursday— February, March, April, June, September, October, November, and December.

CARROLL: Thomas J. Atchison, M.D., President, 292 E. Main St., Carrollton 44615; Nan M. Bissell, M.D., Secretary-Treasurer, 789 N. Lisbon, Box 338, Carrollton 44615. Third Tuesday.

COSHOCTON: Sang M. Suh, M.D., President, 1419 Orange St., Coshocton 43812; Myron Saturski, M.D., Secretary-Treasurer, 149 S. Bridge St., Newcomerstown 43832. Second Tuesday.

HARRISON: Elias Freeman, M.D., President, 232 Jamison Ave., Cadiz 43907; Manuel C. Michelina, M.D., Secretary-Treasurer, High St., Flushing 43977. Second Tuesday.

JEFFERSON: Ronald Agresta, M.D., President, 511 N. Fourth St., Steubenville 43952; Antonio Lugay, M.D., Secretary, 529 N. Fourth St., Steubenville 43952. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Joseph W. Blevins, M.D., Secretary-Treasurer, Conalco, P.O. Box 164, Hannibal 43931. First Wednesday of every 4th month.

TUSCARAWAS: Kenneth A. Van Epps, M.D., President, 404 N. Walnut St., Dover 44622; Donald Bradon, M.D., Secretary, 1716 Cross St., Dover 44622.

Eighth District

Councilor: *Richard E. Hartle, M.D.,* 414 E. Main St. Lancaster 43130.

ATHENS: Bruce Paxton, M.D., President, 125 Lamar Dr., Athens 45701; Lester A. Hamilton, M.D., Secretary-Treasurer, 400 E. State St., Athens 45701. Second Tuesday— March, June, September, and December.

FAIRFIELD: Gordon B. Snider, M.D., President, 1500 E. Main St., Lancaster 43130; John O'Handley, M.D., Secretary-Treasurer, 414 E. Main St., Lancaster 43130. Second Tuesday.

GUERNSEY: Harry H. Tompkins, M.D., President, 1341 N. Clark St., Cambridge 43725; Zosimo T. Maximo, M.D., Secretary-Treasurer, 1213 Woodlawn Ave., Cambridge 43725. First Tuesday except July and August.

LICKING: William H. Overholser, M.D., President, 36 McMillen Dr., Newark 43055; G. Franklin Gabe, M.D., Secretary, 1272 W. Main St., Newark 43055; Mrs. Dorothy Watson, Executive Secretary, 1320 W. Main St., Newark 43055, (614) 344-0331, Ext. 394. Fourth Tuesday each month except June, July, and August.

MORGAN: Asa H. Whitacre, M.D., President, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM: Charles I. Cerney, M.D., President, Bethesda Hospital Med. Library, 2447 Maple Ave., Zanesville, 43701; George M. Kopf, M.D., Secretary-Treasurer, 2315 Maple Ave., Zanesville 43701. First Tuesday.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Michael P. Clouse, M.D., President, Clouse Clinic, W. Main St., Somerset 43783; Sydney N. Lord, M.D., Secretary-Treasurer, E. Main St., Somerset 43783.

WASHINGTON: Fortunato Macatol, M.D., President, 102 Wyandotte Dr., Marietta 45750; Rashid Ahmed, M.D., Secretary, Marietta Memorial, Ferguson & Matthews St., Marietta 45750. Second Wednesday except June, July, August, and September.

Ninth District

Councilor: *Thomas W. Morgan, M.D.,* Holzer Medical Center Clinic, P.O. Box 344, Gallipolis 45631.

GALLIA: Richard G. Patterson, M.D., President, Holzer Medical Clinic, P.O. Box 344, Gallipolis 45631; Donald M. Thaler, M.D., Secretary-Treasurer, First Ave. & Cedar St., Gallipolis 45631.

HOCKING: Owen F. Yaw, M.D., President, 461 E. Second St., Logan 43168; John W. Doering, M.D., Secretary-Treasurer, 42 N. Spring St., Logan 43138.

JACKSON: John M. Cook, M.D., President, Oak Hill Hospital, Oak Hill 45656; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Barney Osborne, M.D., President, 6th & Pine Sts., Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 1230 Navajo Trail, Ironton 45638.

MEIGS: Selim Blazewicz, M.D., President, 112 E. Main St., Pomeroy 45769; Joseph J. Davis, M.D., Secretary-Treasurer, 306 N. Second St., Middleport 45760. When called.

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County Society Officers *(continued)*

PIKE: Albert M. Shrader, M.D., President, 196 Emmitt Ave., Waverly 45690; Kenneth A. Wilkinson, M.D., Secretary-Treasurer, Route 2, Hilltop Medical Center, Waverly 45690. First Tuesday.

SCIOTO: Miller F. Toombs, M.D., President, Wheelersburg 45694; Doyle E. Campbell, M.D., Secretary-Treasurer, 1715 27th St., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, (614) 354-7581. Second Tuesday.

VINTON: No active society.

Tenth District

Councilor: *J. Hutchison Williams, M.D.,* 4355 Sharon Ave., Columbus 43214.

DELAWARE: David W. Nardin, M.D., President, 43 Northwood Dr., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 6 South Main St., Magnetic Springs 43036. Third Tuesday—March, May, September, and December.

FAYETTE: Byers W. Shaw, M.D., President, 616 Willard St., Washington, C.H. 43160; Marvin H. Roszmann, M.D., Secretary-Treasurer, 1005 E. Temple St., Washington C.H. 43160. Second Friday.

FRANKLIN: James W. Kilman, M.D., President, 410 W. Tenth Ave., Columbus 43210; J. Richard Briggs, M.D., Secretary, 423 E. Town St., Columbus 43215; James S. Imboden, Executive Director, 600 South High St., Columbus 43215, (614) 224-6116. April, August, September, and October.

***KNOX:** James Carhart, M.D., President, Medical Arts Bldg., Coshocton Rd., Mt. Vernon 43050; James H. Risko, M.D., Secretary-Treasurer, 307 Vernedale Dr., Mt. Vernon 43050. First Wednesday.

MADISON: Theodore J. Froncek, D.O., President, 58 E. Main St., West Jefferson 43162; John C. Starr, M.D., Secretary-Treasurer, 1615 N. Choctaw Dr., R6, London 43140. Four meetings a year.

MORROW: Francis W. Kubbs, M.D., President, 140 N. Main St., Mount Gilead 43338; Wm. S. Deffinger, M.D., Secretary-Treasurer, State Route 229W, Marengo 43334. First Tuesday.

PICKAWAY: Carlos Alvarez, M.D., President, 147 Pinckney St., Circleville 43113; Francis W. Anderson, M.D., Secretary-Treasurer, 630 Northridge Rd., Circleville 43113. Second Tuesday except July and August.

ROSS: Roy Manning, M.D., President, 612 Central Center, Chillicothe 45601; Carl Henderson, M.D., Secretary-Treasurer, 398 Chestnut St., Chillicothe 45601. First Thursday.

UNION: John B. Ziegler, M.D., President, 18522 Raymond Rd., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday—February, April, October, and December.

Eleventh District

Councilor: *S. Baird Pfahl, Jr., M.D.,* 521 West Perkins Ave., Sandusky 44870.

ASHLAND: K. C. Krishnamurthi, M.D., President, 1060 Claremont Ave., Ashland 44805; Varalakshmi Dheenan, M.D., Secretary-Treasurer, 203 Maple St., Ashland 44805. First Tuesday.

ERIE: Harry L. Hoffman, M.D., President, 1221 Hayes Ave., Sandusky 44870; John Cook, M.D., Secretary, 3004 Hayes Ave., Sandusky 44870; Mrs. David Wolfert, Executive Secretary, Scheid Rd., Box 381 E, Huron 44839, (419) 433-3097. Second Tuesday except July and August.

HOLMES: William Powell, M.D., President, 9 W. Adams, Millersburg 44654; Paul Roth, M.D., Secretary-Treasurer, N. Main St., Killbuck 44637. Third Monday.

HURON: D. Ross Irons, M.D., President, Firelands Medical Center, Bellevue 44811; Shan A. Mohammed, M.D., Secretary-Treasurer, 3 Milan Manor Dr., Milan 44846. Second Wednesday— February, April, June, October, and December.

LORAIN: Joseph Sciarrotta, M.D., President, 1195 Floral Dr. #3, Lorain 44055; Kenneth O'Connor, M.D., Secretary-Treasurer, 319 Michigan Ave., Elyria 44035; Carol Boyson, Executive Secretary, 1480 N. Ridge Rd., E., Elyria 44035, (216) 324-3093 and (216) 233-6561. Second Tuesday except June, July, and August.

MEDINA: Robert E. Welty, M.D., President, 750 E. Washington, Medina 44256; Alfredo R. Austriaco, M.D., Secretary-Treasurer, 750 E. Washington, Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, (216) 725-5331. Third Thursday except December and summer.

RICHLAND: Robert E. Barkett, M.D., President, 341 Cline Ave., Mansfield 44907; John L. Marquardt, M.D., Secretary-Treasurer, 330 Glessner Ave., Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, (419) 522-3411. Third Thursday except June, July, and August.

WAYNE: Eric W. Walter, M.D., President, 1761 Beall Ave., Wooster 44691; Walter H. Kearney, M.D., Secretary, 1740 Cleveland Rd., Wooster 44691. Second Wednesday.

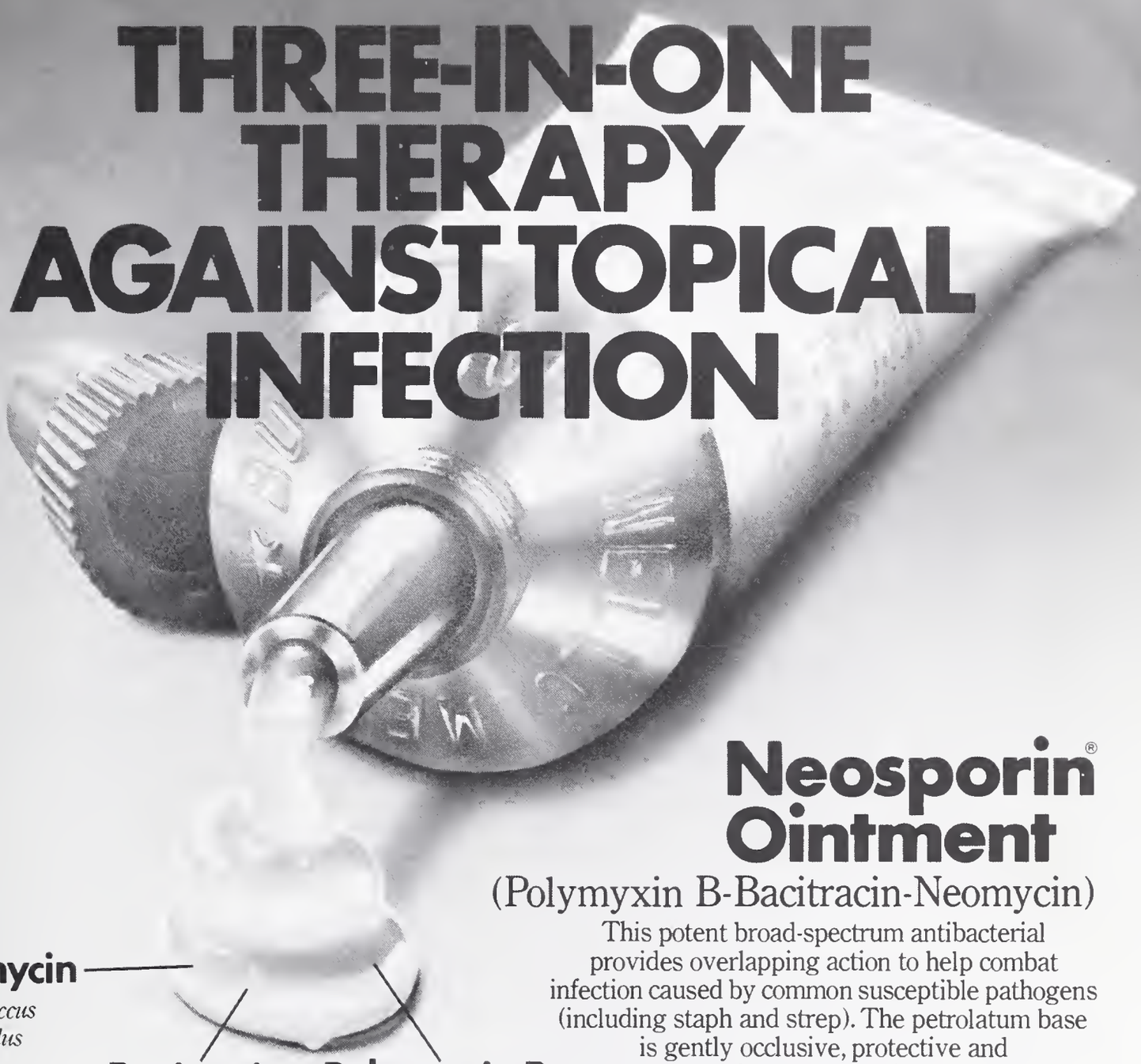
Twelfth District

Councilor: *William Dorner, Jr., M.D.,* 750 W. Market St., Akron 44303.

PORTAGE: Pedro Montemayor, M.D., President, 2627-B S.R. #59, Ravenna 44266; Alif A. Kuri, M.D., Secretary-Treasurer, 250 S. Chestnut, Ravenna 44266.

SUMMIT: Fred F. Somma, M.D., President, St. Thomas Hospital, 444 N. Main St., Akron 44310; H. Wendell King, M.D., Secretary, 185 W. Cedar St., Akron 44307; S. H. Mountcastle, Managing Director, 430 Grant St., Akron 44311, (216) 434-1921. First Tuesday of January, March, May, July September, and November.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

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North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, February 19, and Sunday, February 20, 1977, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council (with the exception of Drs. Maurice F. Lieber and S. Baird Pfahl, Jr.); Dr. P. John Robechek, Cleveland, Chairman of the Ohio Delegation to the AMA: Dr. John H. Ackerman, Columbus, Ohio Director of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel: David L. Rader, Columbus, Vice President-Administration, The Physicians Insurance Company of Ohio; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Mulgrew, Holcomb, Ayish, Torrens, Mrs. Wisse, Mrs. Dodson, Ms. Doll, Mrs. Jacobson, and Mrs. Franklin, of the OSMA Staff.

Those present Sunday were: All members of the Council (with the exception of Drs. John J. Gaughan, Lieber and Pfahl); Mr. Pohlman; and Messrs. Page, Edgar, Gillen, Clinger, Ayish, Torrens, Mrs. Wisse, Mrs. Dodson, Ms. Doll and Mrs. Jacobson of the OSMA Staff.

The president introduced three new members of the executive staff, Mr. Rick Ayish, Assistant Director, Department of State Legislation; David C. Torrens, Assistant Director, Department of Continuing Medical Education, and Judith P. Franklin, Editorial Assistant, Department of Communications.

"COST EFFECTIVENESS ROUND TABLE"

The president discussed the issues involving the cost of medical care and, upon his recommendation, the Council authorized him to appoint a "Cost Effectiveness Round Table" for the purpose of exploring the problem and the avenues to its solution.

MINUTES

The minutes of the December 11-12, 1976 meeting of the Council **were approved.**

OHIO DIRECTOR OF HEALTH

Dr. Ackerman announced that April will be observed as "Ohio Department of Health Immunization Action Month." He stated that the Secretary of the Department of Health, Education, and Welfare has released the bivalent (A/New Jersey and A/Victoria) and Type "B" monovalent influenza vaccines and that new type "consent forms" are available from local health departments. He said that 785,000 doses of bivalent vaccine were given to high risk people during the campaign, or 36 percent of those eligible. An evaluation of the program via a questionnaire to 1,700 members of the Ohio Academy of Family Practice is in progress.

About a thousand cases of rubeola measles are occurring in Ohio, and since there will probably be more when the schools reopen, Dr. Ackerman urged vaccination and re-vaccination where indicated.

Discussing fiscal problems, Dr. Ackerman said that the administration's budget request for the Department to cover the next biennium is $133 million. He said that if attempts to cut the budget by 17 percent are successful, the Department will lose $15 million in federal funds.

MEMBERSHIP

Membership statistics were reported by Mrs. Wisse. Ohio was able to end the year with over 8,000 AMA members, retaining nine AMA delegates and alternate delegates.

FISCAL MATTERS

Dr. Rinderknecht presented the minutes of a meeting of the Committee on Auditing and Appropriations, held February 18, 1977. The minutes **were approved.**

The Committee recommended to the Council the approval of a request of the Committee on Public Relations that up to $25,000 be appropriated from the Malpractice Research Fund to publish the OSMA-Management Horizons research study on attitudes of the public toward physicians and toward the professional liability problem, and to implement a number of recommendations resulting from the findings. By official action, the Council **approved** the appropriation and the implementation of the program.

A list of expenses incurred by the Professional Liability Task Force on various projects was approved for payment.

AMERICAN MEDICAL ASSOCIATION

Dr. Robechek reported for the AMA delegation.

The Council **approved** the draft of a communication to the AMA concerning the proposal discussed at the December meeting of the AMA House of Delegates, wherein the AMA would be permitted to direct bill physicians for AMA dues.

The Council reaffirmed its policy with regard to maintaining the strength of the federation of county medical societies, state associations, and the American Medical Association.

A number of candidates for AMA Councils and Committees were discussed, and suggestions forwarded for consideration.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Mrs. Dodson reported on plans for the 1977 Annual

Meeting and contemplated continuing medical education programs throughout the year.

MEDICAL ADVANCES INSTITUTE

The Council **approved** the use of the Association name in connection with a publication of Medical Advances Institute and Battelle Memorial Institute, contingent upon minor changes in cover design and the deletion of the first paragraph of the brochure. The publication involved a description of "a computerized concurrent hospital peer review system — batch mode." The Council then recessed to convene a meeting of the administrative members of Medical Advances Institute to elect the Board of Trustees of MAI and to conduct other business.

After the Council reconvened in regular session, it received, for information, a letter dated December 10, 1976, from Vergil N. Slee, M.D., President of the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, addressed to James L. Henry, M.D., Vice President of Medical Advances Institute, with regard to the marketing of the "batch" system developed by Medical Advances Institute.

Dr. Hartle reported for the Ad Hoc Subcommittee to Study the Proposed Ohio Health Data Corporation. Further consideration of the subject was delayed until additional clarifying information concerning the proposal can be presented to the Council at its next meeting.

OHIO MEDICAL INDEMNITY, INC.

A report on recent meetings of the OMI Executive Committee and the Board of Directors was given by Mr. Gillen.

PICO

The Council received for information a report on the PICO Shareholders Meeting, held December 26, 1976.

Mr. Rader reported on recent developments with regard to the Physicians Insurance Company of Ohio, which began doing business on December 28, 1976, pursuant to a Certificate of Authority issued by the Ohio Department of Insurance on that date. As of the date of the Council meeting, the company had issued approximately 1,100 quotes on premiums and coverages and had issued approximately 700 policies.

The Underwriting Committee, the Investment Committee, the Claims Committee and the Budget and Finance Committee of PICO have been very active. The Board of Directors has had two meetings since the beginning of business, one December 28 and on February 18.

The PICO Board has also approved the organization of the Medical Premium Finance Company and the PICO Insurance Agency, both of which are wholly-owned subsidiaries of PICO, and both of which are in operation.

It was announced that OSMA is surveying its membership to determine whether there are other lines of insurance in which PICO can serve OSMA members.

COMMITTEE REPORTS

Committee on Public Relations

The minutes of the January 19, 1977 meeting of the Committee on Public Relations were presented by Ms. Doll.

The bulk of the report had to do with recommendations of the committee for implementing the public opinion survey conducted by Management Horizons, at the direction of the Task Force on Professional Liability, and later referred to the Committee on Public Relations for implementation.

The committee suggested five major ways to implement the project, including a report which will be distributed without charge to those who contributed to the research fund. A second project will be a smaller booklet of highlights concerning the findings of the survey which will be given to all members for distribution to the public. In addition, there will be articles for public opinion publications, medical journals, and consumer publications; press seminars; and membership seminars to make physicians aware of public attitudes and how they can conduct their practices to receive increased public approbation. The fiscal aspects of the project are reported in the minutes of the Committee on Auditing and Appropriations reported under the heading "Fiscal Matters."

The report of the committee **was approved.**

Committee on Education

The minutes of the January 19, 1977 meeting of the Committee on Education were presented by Mrs. Dodson and **were approved.**

Ad Hoc Committee on Quality Health Care

The minutes of the January 26, 1977 meeting of the Ad Hoc Committee on Quality Health Care were presented by Mr. Clinger, for information.

Committee on Cancer

The minutes of the January 23, 1977 meeting of the Committee on Cancer were presented by Mr. Clinger.

In approving the minutes, the Council supported the recommendation for regional continuing education programs on cancer, financially underwritten by the Ohio Division of the American Cancer Society.

With regard to the subject of legislation for a special sales tax on cigarettes sold in Ohio with all revenues earmarked to the Ohio Department of Health to be used in cancer control, the Council reaffirmed its policy of March 13, 1976, accepting the proposal in principle but voting not to actively pursue the matter at this time, since the present social climate decries additional taxation, and because experience has demonstrated that so-called "earmarked" funds often do not reach their destination.

(continued on page 254)

Proceedings of the Council *(continued)*

Ad Hoc Committee on Second Opinion on Elective Surgery

The report of the Ad Hoc Committee on Second Opinion on Elective Surgery meeting of February 18, 1977, was presented by Dr. Hogg. The committee presented for Council's consideration a set of guidelines for elective surgery consultation programs. The guidelines were amended and adopted by the Council to read as follows:

PREAMBLE

Despite recent publicity to the contrary, the concept of the "Second Surgical Opinion" is not new.

The medical profession has always recognized and supported right of any patient to request a second opinion or consultation.

Because the "Second Surgical Opinion" is now being offered as an insurance benefit under unduly varying conditions, the following guidelines are offered for the guidance of physicians who may be considering whether to participate in this activity.

OSMA Guidelines for Pilot Programs — Elective Surgical Consultation Programs

The Elective Surgical Consultation Program (ESCP) provides insurance coverage for a patient contemplating elective surgery who desires a second professional opinion.

The following elements should be present in any second opinion program.

1) Obtaining a second opinion is a **voluntary** patient option.
2) Lack of agreement in a second opinion does not deny a patient the benefits of his health insurance policy.
3) The consultant should directly discuss the results of the consultation with the patient.
4) If possible, the structure administering the program should be under the jurisdiction of the appropriate physician organization. This includes such aspects as: referral process; data release and marketing materials.
5) The ESCP should provide a benefit when the original surgical consultant feels additional consultation would be helpful in determining the indicators for surgery.
6) A third opinion should be a covered benefit on request of the patient.
7) The reimbursement by the insurer for the second consultation should be reasonable.
8) Any physician agreeing to serve as a consultant, agrees not to perform the surgery, not to refer the patient to a colleague with whom he is financially related, nor otherwise be involved in the treatment for the specific condition which resulted in request for second or third opinion.

Resource Material: Report K — AMA (A-76)
Report J — AMA (C-76)

Ad Hoc Committee on Bylaw Amendments

A report from the Ad Hoc Committee on Bylaw Amendments was presented by Dr. Dorner.

The Council authorized the committee to prepare, for introduction on behalf of the Council, amendments to eliminate Chapter 9 of the Bylaws with regard to standing committees, in order to establish special committees which are mission-oriented and can be replaced by other committees when their objectives have been accomplished.

The committee was also charged with developing a resolution to make it possible for retired or disabled physicians to retain their active membership despite requirements of 150 hours of continuing medical education for licensure, possibly making them ineligible under the present bylaws.

Committee on Scientific Work

The minutes of the February 5, 1977 meeting of the Committee on Scientific Work were presented by Mrs. Dodson. The minutes **were approved** and the Council suggested that alternative plans for convention exhibits be discussed by the Council at its "unstructured" session next summer.

PEER REVIEW

The Council discussed the matter of the resumption of peer review activities with regard to physicians' fees and voted that a resolution on that subject be submitted at the May session of the House of Delegates.

DISABLED PHYSICIANS CONFERENCE

The Disabled Physicians Conference in Atlanta, Georgia, was discussed by Mr. Clinger. The Council reviewed reports from the *AMA News* which featured Mr. Clinger as one of the headline speakers at the conference.

COUNCILOR REPORTS

The Councilors reported on activities in their respective districts.

Mr. Mulgrew received praise from Dr. Hogg for his commendable representation of the OSMA at a hospital staff meeting in the First District.

FEDERAL LEGISLATION

Mr. Edgar reported several matters involving federal legislation.

The Council commended Wright State University for its action in refusing to accept medical school admissions dictated by the Secretary of Health, Education, and Welfare, even if such refusal meant forfeiting federal funds.

The Council authorized a statement on Medicaid and Medicare Fraud and Abuse Amendments of 1977 (H.R. 3).

The Council also authorized a statement on H.R. 2504, the bill to enhance Medicare and Medicaid payments to physician extenders in rural clinics.

STATE LEGISLATION

Mr. Mulgrew discussed a number of proposals which are being considered by the State Legislature, including H.B. 164, containing amendments to H.B. 244, of the last session, having to do with commitment procedures.

He discussed H.B. 213, which would repeal the statutory informed consent form and hold that hospitals shall not be liable for a physician's failure to obtain

informed consent. Hearings will be held on March 10, 1977.

He also discussed the following legislative issues:

Generic Drug Substitution — requested Council to ascertain the opinion of members in their districts on the issue.

Informed the Council of H.B. 209 — a bill to establish a board of physical therapy.

S.B. 130, a bill to permit anesthesia assistants to give anesthetics under the supervision of a physician.

H.B. 252, legislation that will establish Departments of Geriatric Medicine at all state-supported medical schools.

H.B. 267, a bill amending the present jury duty law in Ohio by retaining the physician's exemption for jury duty on written request.

State legislative matters were referred to the new Committee on State Legislation, appointed by the Council. The committee members are: S. Baird Pfahl, Jr., Sandusky, Chairman; Robert Ailes, Sandusky; John E. Albers, Cincinnati; Alford C. Diller, Convoy; Stewart B. Dunsker, Cincinnati; Clarence Lee Huggins, Jr., Cleveland; Steven Kovacs, Cleveland; Daniel M. Murphy, Marion; Russell J. Nicholl, Cleveland; Milton M. Parker, Coumbus; George Paulson, Columbus; John H. Sanders, Cleveland; Robert E. Schulz, Wooster; William E. Sovik, Youngstown; Auxiliary Legislative Chairwoman; and Medical Student Representative.

A letter from Senator Harry Meshel, of the Ohio General Assembly, regarding professional consultant service contracts, was referred to Mr. Ayish for follow-up with Senator Meshel.

CONSTITUTION AND BYLAWS

It was announced that relatively few of the county medical societies have adopted the deletion of the citizenship requirements.

Amendments to the Constitution and Bylaws of the Butler County Medical Society **were approved.**

LEGAL COUNSEL REPORT

Problems arising from the refusal of a hospital to accept pre-admission testing results done in a laboratory outside the hospital were discussed. The problem was referred to a special Ad Hoc Committee for study and evaluation: Dr. Hogg, chairman; Dr. Pichette, Dr. Gaughan and Dr. Thomas. Mr. Pohlman was instructed to pursue the legal aspects of the problems and to work with the Ad Hoc Committee.

Legal Counsel was authorized to investigate, with the assistance of an Ad Hoc Committee of the Council, the status of the Mahoning County Medical Society cases pending in Cleveland Federal Court and to report back at the next meeting of the Council.

TASK FORCE ON PROFESSIONAL LIABILITY

Mr. Campbell reported for the Task Force on Professional Liability.

DR. HOGG NOMINATED

The Council received a communication from the Academy of Medicine of Cincinnati, nominating Stephen P. Hogg, M.D., First District Councilor, for the office of President-Elect of the Ohio State Medical Association.

NATIONAL HEALTH SERVICE CORPS

Mr. Holcomb, in a discussion of recent developments in Ohio, pointed out that under the new law, the National Health Service Corps physicians can be placed without the recommendation of the Ohio State Medical Association, but they are still required to consult with the county medical society.



Left to right: Henry A. Crawford, M.D., AMA Delegate; Theodore J. Castele, M.D., AMA Alternate Delegate; and John J. Gaughan, M.D., OSMA Fifth District Councilor, at a reception for John H. Budd, M.D., (see page 200).

HEALTH TESTING PROGRAMS

A letter from the Farm Bureau Federation, with regard to the sponsorship of multiphasic health testing programs by that organization, was received by the Council. The Council instructed the staff to prepare for publication another article on the relationship and responsibility of the physician to these testing programs. It was also suggested that the Ohio Farm Bureau Federation be cautioned that it should be incumbent on that organization to insist on quality controls in this type of project.

OHIO MEDICAL EDUCATION AND RESEARCH FOUNDATION

The Council voted to proceed with the organization of the Ohio Medical Education and Research Foundation, in accordance with corporate documents prepared by legal counsel.

EXECUTIVE SESSION

An Executive Session of the Council was convened. The Council reconvened in regular session and then adjourned.

The next meeting of the Council is scheduled for April 2-3, 1977.

ATTEST: Hart F. Page
Executive Director

THE OHIO STATE Medical Association News

Medical Board Activity

The following is a list of activities and actions undertaken from February 1, 1977 to February 28, 1977, by the Ohio State Medical Board.

LICENSURE ACTIVITY

American & Canadian Graduates		
Licensed by Endorsement	M.D.	73
	D.O.	4
Licensed by Examination	M.D.	21
	D.O.	2
Foreign Medical School Graduates		
Licensed by Endorsement		11
Licensed by Examination		45
Sept. 1972 FLEX Board Policy Licenses		5
Endorsements to Other States	M.D.	44
	D.O.	1

ENFORCEMENT ACTIVITY

Formal Citations Issued	0
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act.	4
Voluntary Surrenders of Medical Certificates	1
Arrests for Alleged Illegal Practice of Medicine	2
Formal Hearings on Alleged Violations of the Medical Practice Act	1

MAC Suit Dismissed

The suit challenging HEW's Maximum Allowable Cost Program (MAC) for drugs prescribed for Medicare and Medicaid patients has been dismissed by U.S. District Court Judge Prentice Marshall. He concluded that the suit, brought by the AMA, the Pharmaceutical Manufacturers Association, and five physicians, was without merit. Judge Marshall noted that Congress, in enacting legislation authorizing the program, had a six-year history of trying to grapple with inflation in government health care programs. He also said that the Secretary of HEW was not exceeding his authority in promulgating the MAC program regulations.

Meanwhile, HEW carried through with the implementation of the MAC program. This program provides that when a physician prescribes certain brand name drugs for which there are generic equivalents, HEW will pay only the cost of the generic drug.

National Medicare Fee Schedule

Commenting on a report by Ralph Nader's Health Research Group proposing a national Medicare fee schedule for physicians, AMA Board of Trustees Chairman Raymond T. Holden, M.D., said: "The truth is that Medicare and Medicaid have not paid a fair reimbursement since 1971. While physicians must pay their office staffs at 1977 wage levels, and heat their offices at 1977 fuel prices, and buy professional liability insurance at 1977 premium rates, the government reimburses them at 1975 fee levels." He said the report's proposal to give HEW authority to withdraw hospital privileges of physicians who do not accept Medicare and Medicaid patients "constitutes a repugnant exercise in coercion, a clear abuse of federal power."

Hospital Care Takes Most Of Health Care Dollar

According to the Health Insurance Institute, the proportion of each dollar spent for personal health care that goes for hospital and nursing-home care has risen steadily since 1929, while the share for the other categories has declined. Currently, Americans are paying about 45 cents out of every dollar for hospital bills. Physician and other professional services take about 23 cents out of every dollar, while the remainder goes for nursing-home care, drugs, research, and construction.

FTC Suit Moves Toward Trial

An administrative law judge has certified to the full Federal Trade Commission (FTC) the AMA's motion for FTC reconsideration of its restraint of trade complaint. In addition, the FTC administrative law judge has changed the trial date from June 7 to September 7, 1977. The FTC complaint, regarding advertising by physicians and medical ethics, was issued against the AMA, the Connecticut State Medical Society, and the New Haven Medical Association in December 1975.

Medical History Group to Meet

The Annual Meeting of the Ohio Academy of Medical History will be held on Saturday, May 7, at the Fawcett Center, Columbus. Contact Mrs. Kay Barkley, Jewish Hospital Medical Library, Cincinnati, for information.

Correction

The Journal regrets a typographic error in the Comment by Paul S. Metzger, M.D., that appeared in the February 1977 issue. The last sentence in the third from the final paragraph is incorrect. It should read: "This documentation does not mean to identify physicians and patient records outside of the peer review process but it does mean that an accountability of activity must be available for those nonprofessionals with legitimate interests (foundation, third parties, and patients).

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Classified Ads

Rates: $2.00 per line. Display classified: $4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

PHYSICIANS NEEDED: One or a group. Modern, 2400-square foot, fully equipped, completely furnished, medical-office space for lease or sale. Good location in Lake Erie region. Two accredited hospitals 10 minutes away. Located 40 miles from Toledo Medical College. Call collect 419/547-7409 or write John J. Gedert, M.D., 124 Ridgeview, Clyde, Ohio 43410.

GENERAL PRACTITIONER/FAMILY PRACTITIONER in active practice retiring June 1. Excellent income. West central Ohio, rich agricultural area, some industry, near metropolitan medical centers. JCAH-accredited hospital; full staff privileges and coverage. Reply box 793, c/o Ohio State Medical Journal.

PEDIATRICIAN/NEONATOLOGIST: Solo or associate practice in city of 40,000. Office space, housing, and 250-bed general hospital with privileges available. (See FAMILY PRACTICE POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

FOR SALE: Complete eye-examination and treatment equipment, includes tonography instruments, keratometer, refracting equipment, field testing devices, and various files, cabinets, etc. Can be seen at 303 East Town Street, Columbus, Ohio, Jack R. Bontley, M.D. Call for appointment 614/224-8700.

GENERAL SURGERY RESIDENCY: We have two remaining openings at the 2PGY level beginning July 1, 1977 in our newly activated program. Candidates must be graduates of American or Canadian Schools of Medicine. Contact: Joseph C. Avellone, M.D., Director of Surgery, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland, Ohio 44113.

FOR SALE: North Ohio Ophthalmologist retiring June 1st offers instruments, equipment, office building. Reply Box 791, Ohio State Medical Journal.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

Support OSMA

Pay Your 1977 Dues

Have you paid your medical association dues? If not, this may be the last *Journal* you receive. In May, our mailing list will be cleared of 1976 members who have not renewed in 1977.

The *Journal* is only one of the benefits of OSMA membership. As a member, you also receive the Association's other publications, the *OSMAgram* and *Your Doctor Reports*. These publications highlight the activities planned for members, including continuing education courses, tours, and special programs. In addition, the Association offers a number of insurance programs and one for car leasing.

Equally as important but not as visible is the continued support of physician members in the Ohio Legislature, the U.S. Congress, government medical programs, and public opinion. The Association also is the physician's liaison to such groups as the Ohio State Medical Board and the Ohio State Department of Education.

The OSMA also provides on-going personal communication with members through field representatives and membership services.

So, if your dues are not paid, why not write your check for $125 today. To ensure the unity that results from solid membership through county, state, and national support, include AMA dues of $250 in your check. Remember, the achievements of all three are to your advantage. Your support is essential.

INDUSTRIAL PHYSICIAN

Goodyear Aerospace Corporation has a part-time position on its staff for a General Practitioner or Doctor of Internal Medicine to work in Industrial Medicine.

Goodyear Aerospace is a highly diversified company based on advanced technology in electronic, mechanical, and aeronautical engineering. Our products range from missile guidance systems, underseas warfare equipment, wheels and brakes, radar equipment, and engineered fabric systems.

This offers an opportunity to share a private practice with the expanding field of what is happening in industrial medicine. To discuss possibilities, don't hesitate to call or write Howard A. Walker, Manager of Salary Personnel, Goodyear Aerospace Corporation, 1210 Massillon Road, Akron, Ohio 44315. Phone: 216/794-2286.

EQUAL OPPORTUNTY EMPLOYER—M/F/V/H

SOUTHWEST OHIO: Established family practice. Relocating, associate staying. 10 miles from Dayton. Gross 100M+, no investment. OB if desired, medical school and/or hospital teaching if desired. Reply box 792 c/o Ohio State Medical Journal.

PHYSICIAN WANTED: To assume duties as a general practitioner on beautiful Put-in-Bay Island. Ideal for semi-retirement. This is a summer resort area, but does provide a doctor with a good living the year around. Modern home, offices, light, heat, and power furnished by the community. Contact Gus Cooper, Township Clerk, P.O. Box 218, Put-in-Bay, Ohio 43456. Phone: 419/285-3394.

THREE BOARD-CERTIFIED FAMILY PHYSICIANS looking to recruit family physician graduate or board-qualified or certified family physician as an associate in a semi-rural small town, group practice. Progressive community; local liberal arts college; excellent local community hospital; and 35 miles from Columbus, Ohio. A very good setting in which to practice, live, and raise a family. Contact Granville Medical Center, Inc., Granville, Ohio 43023, phone 614/587-0115.

FAMILY PHYSICIAN: FAAFP, mature, desires association with solo practitioner looking forward to semi-retirement, or small group, to practice six to nine months per year, sharing expenses and time off. Reply Box 787, c/o Ohio State Medical Journal.

PRACTITIONERS: TIRED OF LONG HOURS? Have you considered an exciting, hospital-based specialty? We have one, and an excellent training program in Rehabilitation Medicine. Two vacancies for July 1977. Write Dr. C. Long, CWRU-affiliated Program, Highland View Hospital, 3901 Ireland Dr., Cleveland, Ohio 44122.

WANTED: PHYSICIANS — ALL SPECIALTIES: As search consultants in the health care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals, and other organizations in the health care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. **LEPINOT ASSOCIATES INC., 702 ABBOTT ROAD, EAST LANSING, MICHIGAN 48823.**

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third partner to practice. New facility. Excellent hospital within walking distance. (See **FAMILY PRACTICE POSITION AVAILABLE** ad this issue for more detailed information.) Contact Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

EMERGENCY MEDICINE: Career opportunities available in E.D. medicine. Also short-term and locum tenens. Eight Ohio locations. Flexible work schedules and competitive remuneration. Paid malpractice, vacation, educational leave. Contact Doctor S. Spurgeon or J. W. Cooper toll-free 1-800-325-3982.

INDUSTRIAL PHYSICIAN FULL-TIME: No previous industrial experience required. Acceptable following one-year internship or residency. Normal in-plant medical facility available. Excellent starting salary and large company benefits. Apply: Chief Physician, Lorain Assembly Plant, Ford Motor Company, 5401 Baumhart Road, Lorain, Ohio 44052.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone 216/946-4546.

PHYSICIAN WANTED: General surgeon— Thoracic, experience preferred. To replace retiring surgeon in association with board certified surgeon, northeast Ohio. Small university town. Modern hospital with residency training and medical school affiliation. Reply Box 786 c/o Ohio State Medical Journal.

EXPERIENCED FAMILY PHYSICIAN: Available as locum tenens, minimum 2 months. Reply Box 788, c/o Ohio State Medical Journal.

OFFICE FOR RENT: COLUMBUS. New office building: 5 min. from Mercy Hospital, 10 min. from Mt. Carmel Hospital, and 10 min. from Grant Hospital. Will tailor office to requirements. Ample off-street parking; bus stop on corner. Air conditioned. Phone days: Robert E. Horowitz, 614/444-1151.

TWO PHYSICIANS ASSISTANTS: Cleveland-Clinic-trained. Will be available June '77. NCCPA exam eligible November '77. Honor students desire separate positions in medical or surgical practice. Location of practice: Cleveland and suburbs or any other area of Ohio. Will relocate. Contact: James Andrassy, 2578 East 130, Shaker Heights, Ohio 44120. Phone: 216/229-7504.

(**Editor's Note:** *The Journal presents the above classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.)*

RADIOLOGIST: Board-certified or Board-eligible. To serve as a radiologist at the consolidated Cleveland Veterans Administration Hospital. This hospital is affiliated with the Case Western Reserve University School of Medicine. Salary range $32,500 to $47,500, commensurate with experience and academic qualifications. For more information, call or write the Chief of Staff (11), Veterans Administration Hospital, 10701 East Boulevard, Cleveland, Ohio 44106. Phone: 216/791-3800, ext. 205.

EQUAL OPPORTUNITY EMPLOYER

EMERGENCY DEPARTMENT PHYSICIAN: One full-time or two part-time. Competitive pay scale; 4 wks. paid vacation, 2 wks. educational leave. Good back-up. Pleasant northeast Ohio, growing, rural hospital; 14,000 emergency patients per year. May join emergency dept. corporation after six months. Contact Dr. Rothrock, Dr. Pearce, or Mr. Jacobs, Administrator, Geauga Community Hospital, 13207 Ravenna Rd., (Rte. 44), Chardon, Ohio 44024, Phone: 216/286-6131.

INTERNIST & PHYSIATRIST: For corporation operating in large cities, State of Ohio. Ohio license a must. Board certified or eligible. Fringe benefits available. Salary commensurate with experience. Contact: Allied Medical, Inc., 1925 E. Dublin-Granville Road, Columbus, Ohio 43229, Phone: 614/846-8434.

(continued on page 260)

Classified Ads

OHIO UNIVERSITY HEALTH SERVICE seeks experienced physician to join staff of full-time physicians in a comprehensive student health service. Located in a small town in the wooded hills of southeastern Ohio. Emphasis on preventive medicine and health education programs. Applications from family practitioners and/or all areas of medical specialty are encouraged. Ohio licensing required. Salary $32,000 plus liberal benefits. E. D. Mattmiller, M.D., Director, Hudson Health Center, Athens, Ohio 45701. Telephone: 614/594-5521.

An Equal Opportunity Employer

PHYSICIAN WANTED: General Practice physician—new office, ready to move into! Northcentral Ohio, pop. 10,000. Ideal environment. Golf, skeet/trap shooting, hunting. Excellent community rec. program. Boating nearby. Southern gateway Lake Erie Islands vacation area. Good schools. Midway Cleveland/Toledo, 100 mi. north Columbus. Modern 68-bed hospital. New office on hospital grounds. Brochure sent on request. Call or write Physician Recruitment Committee, c/o Supt., Bellevue Hospital, 811 North West Street, Bellevue, Ohio 44811, phone: 419/483-4040.

ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice, hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 43227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

EMERGENCY PHYSICIANS: Cleveland, Ohio. Opportunity to pursue career in long-established, compatible professional group providing emergency services to three hospitals in Northeast Ohio. Enjoy four weeks vacation, two weeks professional development, and a superior starting income with outstanding ancillary benefit plan. An Ohio license is prerequisite and membership in ACEP is desired. We are most interested in career-oriented individuals desirous of growth, security, and professional enhancement. If qualified and interested, please call Ronald Kimes, Group Manager, Emergency Associates, Inc. For further information and a personal interview phone: 216/461-5255, Monday through Friday, 8 AM to 5 PM.

FAMILY PRACTICE MEDICAL POSITIONS AVAILABLE: Family practitioners and director of family practice center wanted. Solo, group or association practice available. Both existing or new practice opportunities available. 250-bed, general/regional hospital within walking distance of offices with privileges available. Hospital is an exceptionally well-equipped, general, short-stay facility with excellent medical staff that is committed to the family practice/primary care approach. Industry and agriculture provide sources of income to 40,000-70,000 people living in city and county. Total area population 250,000. Excellent schools and a branch of Ohio State University. Contact Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

VAIL, COLORADO, FOR RENT: Ski vacation. Days or weeks in beautiful Rockies. Spacious condominium ready for living. Fireplace, three outdoor balconies, two bedrooms and two-bed loft. Write PAM Properties, P.O. 5097, Cincinnati, Ohio 45205, or call 303/476-5532 and refer to Timberfalls 809.



FOR SALE: New two-story, brick, medical bldg. in Cleveland suburb, Euclid. Three doctors' offices first floor, two suites or apartment second floor. Parking for 20 cars front and rear. On bus stop. Two blocks from shopping area. Price $90,000. Physician can take over established general practice office. Gross income from rent $12,000 per year. See by appointment 4 to 7 PM except Thursdays. Phone 216/481-3058 or 216/383-8225, Euclid, Ohio.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

PHYSICIAN WANTED: Excellent opportunity and environment. Physician needed to practice general medicine in large outpatient clinic and 38-bed, fully accredited hospital. Must possess empathy toward college-age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, Indiana 47907. Phone: 317/749-2441.

EQUAL ACCESS/EQUAL OPPORTUNITY EMPLOYER

FOR SALE: Nine-room, air-conditioned, office building and parking lot with inner city, general practice in Northern Ohio. For $35,000, you can start with an established practice and no rent. Reply Box 790 c/o Ohio State Medical Journal.

RADIOLOGIST: An associate radiologist is needed in hospital practice of radiology including nuclear medicine. Northcentral Ohio, rural college town. Financial arrangement negotiable. Ample time for vacation and professional education. Write: Radiologist, P.O. Box 527, Ashland, Ohio 44805.

THE TOLEDO HOSPITAL invites applications for the position of Director of Education-Obstetrics and Gynecology. This individual will plan, organize, develop, and coordinate obstetric and gynecologic medical education programs for medical students, residents, and fellows in this 728-bed, community hospital.

As the Regional Perinatal Center for Northwest Ohio, affiliated with the Medical College of Ohio at Toledo, The Toledo Hospital offers a dynamic and progressive approach to obstetric and gynecologic care.

With 3,300 deliveries, over 200 newborn transports per year, and 9,000 patient days of gynecologic care, an exciting and progressive program awaits the right candidate.

Candidates should submit curricula vitae to T. G. Kirkhope, M.D., c/o The Toledo Hospital, Department of OB/GYN, 2142 N. Cove Boulevard, Toledo, OH 43606.

OB/GYN: For contract with family planning/termination/laparoscopy clinic in Northeast Ohio. Private practice. $60,000/year. Reply Box 789 c/o Ohio State Medical Journal.

THE OHIO STATE Medical Journal

MAY 1977
Volume 73, Number 5



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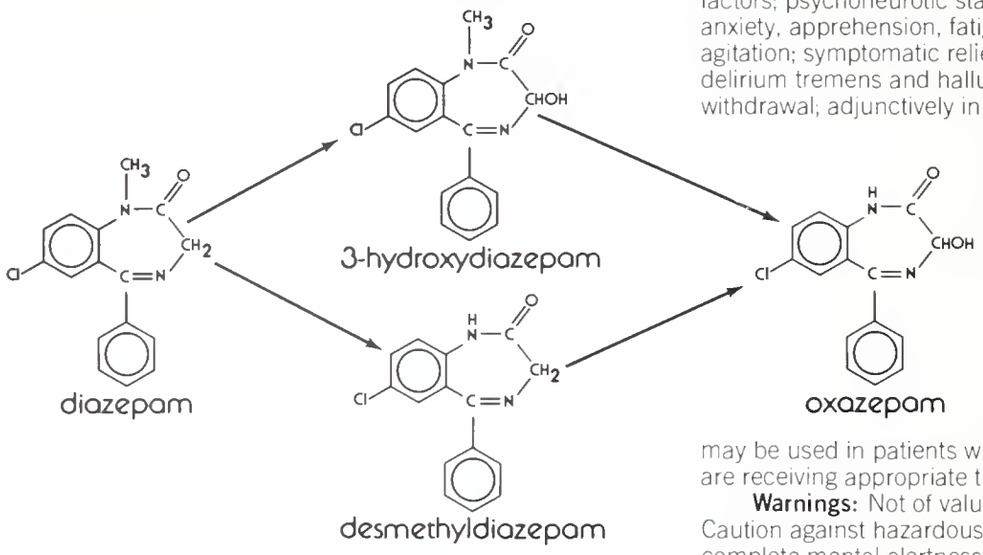
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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Take Your Legislator to Lunch

OSMA members attending the Annual Meeting in Columbus are strongly encouraged to bring their state legislators to the OMPAC luncheon, May 17. This year's speaker is the world-renowned political analyst, Richard Scammon. He is both entertaining and highly informative.

This luncheon will give OSMA members the opportunity to discuss the interests of medicine with their local legislators. To be effective politically, every physician should take the time to know his state and federal legislators. These legislators have ever-growing responsibilities in the health care field, and physicians must learn to influence the political process through political action.

Membership in the Ohio Medical Political Action Committee (OMPAC) is one step toward political action. However, a physician's work cannot stop with OMPAC membership or his checkbook. OSMA members should participate in local political races, assist candidates, and, most importantly, get to know the candidates personally. Physicians are the experts in medical affairs. However, if the politician does not know the physician, he will ask advice from a non-physician.

A lobbyist in Columbus without local legislative contacts is like a tree without roots. It may look sturdy; but in a strong wind, it will topple. The OMPAC luncheon offers OSMA members the perfect opportunity to meet with legislators. Please make use of it.

Advertising Bill Introduced

A bill to repeal the statutory prohibition of advertising by licensed professionals has been introduced in the Ohio Senate. S.B. 240 (Bowen, D-Cincinnati), if enacted, would permit unrestricted advertising by dentists, physicians' assistants, physicians, podiatrists, chiropractors, and veterinarians. The bill also makes it a criminal offense for a professional organization (eg, OSMA) to directly or indirectly enact a rule limiting the right of a member to advertise prices. The bill has been referred to the Senate Commerce and Labor Committee. In addition, Senator Bowen introduced a resolution (SJR-17) that requests the Ohio Supreme Court to permit lawyers to advertise their prices.

Informed Consent Bill in Senate

The Ohio House of Representatives passed the OSMA-supported informed consent bill, Amended House Bill 213 (Murdock, R-Cincinnati and Lehman, D-Cleveland). The legislation repeals the unworkable statutory form included in H.B. 682 and exempts hospitals from liability when non-employee physicians fail to obtain a valid informed consent from patients. The Judiciary Committee amended the bill to require that any written form that meets the statutory requirements include the name(s) of the physician(s) actually performing the surgical or medical procedure. Another amendment subsequently defeated during the floor debate would have made the hospital liable for any independent contractor physician's failure to get a valid informed consent. This language was removed when an amendment by Representative William Batchelder (R-Medina), Corwin Nixon (R-Lebanon), and William O'Neill (R-Columbus) received 46 votes. The legislation has gone to the Senate for hearings. The OSMA hopes for quick passage by the Senate.

Senate Approves Generic Drug Bill

The Senate approved S.B. 45 (Freeman, D-Canton), legislation to repeal Ohio's anti-substitution law, by a vote of 31 to 2. One major amendment was included on the Senate floor requiring every pharmacist to establish and maintain an in-house formulary list of generic drugs he has available. The bill now goes to the House Judiciary Committee for consideration, taking priority over a similar piece of legislation, H.B. 151 (Orlett, D-Dayton), that had been receiving hearings in the House Committee.

The Senate Education and Health Committee favorably voted a week ago to send S.B. 45 before the full Senate. The legislation was substantially amended in the Committee with some of the concerns of the OSMA being addressed in the amendments. It is absolutely essential that adequate physician control of drug therapy be included in any drug substitution legislation.

The Department of State Legislation will continue to work with the members of the Judiciary Committee to address the problems that still remain in Senate Bill 45. OSMA members are encouraged to contact the Department of State Legislation (614/228-6971) regarding this legislation, particularly in providing physician testimony before the House Committee.

"Patients' Bill of Rights"

Senator Marigene Valiquette (D-Toledo) has sponsored Senate Bill 202, a so-called "Patients' Bill of Rights." Similar to last session's S.B. 363, the new legislation has increased the number of "rights" from 16 to 19. Most of the rights include a degree of latitude through the use of words such as *if reasonably possible* and *within reason,* although two of the three new rights contain no range of flexibility. The language contained in the 18th right would possibly allow attorneys to be present during surgical procedures, other treatments, or at any time the patient desires. The OSMA opposed last session's "Patients' Bill of Rights" and will be examining S.B. 202 and reporting its potential ramifications.



the federal scene

(Courtesy the OSMA Department of Federal Legislation)

In the name of the "sunshine law," the federal government released during March the names of physicians, groups, and laboratories that did more than $100,000 in Medicare business in 1975.

The over-$100,000 category included 409 physicians, 1,752 medical groups, and 58 laboratories. This compared to 2,533 physicians, dentists, and pharmacies listed in the latest Medicaid report of more than $100,000 intake last November.

The AMA branded the releasing of the names as "only serving to badger a large segment of the profession and to establish guilt by innuendo." AMA Executive Vice-President James Sammons, M.D., said: "There is a basic dishonesty in the broadcast release of the names of individuals receiving Medicare payments." Dr. Sammons added that if "HEW thinks any physician on this list is guilty of fraud, HEW should say so. We will assist in any case where there is good reason to suspect wrong-doing."

Dr. Sammons said the physicians were identified by HEW as individual recipients of Medicare funds, whereas the payments are often for services provided by many others as well. He noted that many of the physicians listed are hospital-based radiologists, pathologists, and anesthesiologists. "We would also point out that these services are paid for at a rate set by Medicare and based on prevailing charges two years out of date."

Predictably, press reaction was uneven. Some press took the trouble to check before using the story. Most press did not. All too typical were headlines like this one from the *Fort Lauderdale Sun-Sentinal:* "Hew Releases Names of Doctors on Medicare Gravy Train."

Few stories bothered to explain that the figures cited are gross, not net, or that HEW's dollar totals included not only payments to the physician but payments made directly to the beneficiary where the beneficiary is responsible for paying the physician's bill.

Having gone through a similar experience in November of 1976, when the Social and Rehabilitation Service made public a list of physicians, dentists, pharmacies, and laboratories that had received $100,000 or more from Medicaid in 1975, the AMA immediately began checking for accuracy as many of the names and amounts listed as paid to solo practitioners as possible.

Some 166 physicians listed in solo practice were contacted in 30 states and the District of Columbia by the AMA. Of this group, 82 were incorrectly listed as solo practitioners, 5 had incorrect amounts attributed as paid to them, and 22 reported both the solo designation and the amount were incorrect. Some 65.7 percent of the information released on the 409 physicians listed as solo practitioners, therefore, was incorrect.

Complaints from individual physicians victimized by these inaccuracies poured into the press. A roundup by the Associated Press pointed out some of the injustices done by the HEW release in which two out of three solo practitioners were inaccurately listed. The *Washington Star* took editorial note of HEW's inaccuracies under the heading: "A Sloppy Piece of Work."

The physicians contacted by the AMA and state medical societies reported harassment by angry patients, crank telephone calls, children taunted at school as the children of crooks, anonymous threats, attacks by colleagues, and continuing embarrassment within their communities.

A number of Congressmen inserted remarks into the *Congressional Record* with respect to HEW's disgraceful performance.

HEW Secretary Joseph A. Califano has privately admitted dismay and has publicly stated that a corrected list would be forthcoming.

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COVER: The Ohio State House on a spring afternoon. (Photograph by Robert D. Clinger.)

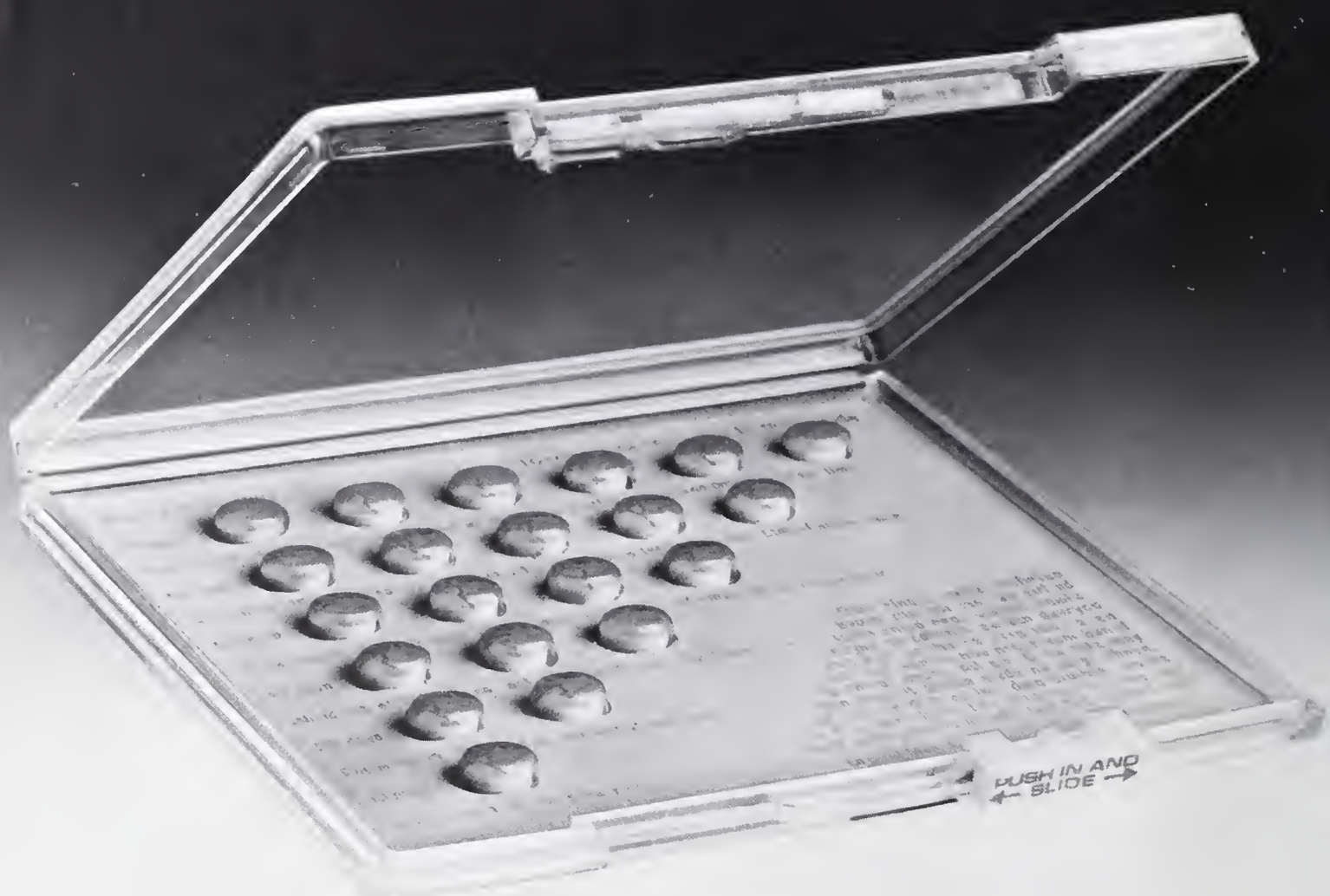
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Day at the Legislature

Linda A. Jacobson

The month of March marked the annual OSMA Auxiliary "Day at the Legislature." This event is designed to familiarize physicians' spouses with the process of state government and the people involved. In addition, emphasis is placed on how Auxiliary members can work with and through state government in order to achieve goals they have established.

D. Brent Mulgrew, Esq., Director of the OSMA Department of State Legislation, and his Assistant Director, Richard A. Ayish, joined forces with Auxiliary leaders to plan the day's activities. The OSMA staff members briefed those in attendance on legislation currently moving through the Ohio Senate and House of Representatives. They also guided a tour of the State House and chaired several meetings of Auxiliary members.

During the day, Auxiliary members had the opportunity to sit in on committee hearings and floor sessions. They were also able to meet many of their elected officials. Most of the 133 senators and representatives gathered at the Sheraton-Columbus for lunch with the Auxiliary. Auxilians dined with their respective senator and/or representative. This atmosphere allowed for considerable sharing of ideas.

The evening prior to the "Day at the Legislature," Auxilians hosted a dinner for the Speaker of the House of Representatives, Vernal G. Riffe, Jr., Portsmouth. In his remarks following dinner, Speaker Riffe stressed the need for communication between constituents and their elected officials.



OSMA Auxiliary Legislation Committee Chairman Mrs. W. J. Pignolet listens to Speaker Vernal G. Riffe, Jr.



Left to right: Speaker Vernal G. Riffe, Jr.; OSMA Auxiliary President Mrs. William Myers; and OSMA Auxiliary President-Elect Mrs. Albert May.

"Communication on the state level is exceedingly important," said Speaker Riffe, "because the State Legislature will enact more legislation in one year than the United States Congress in five."

He told the Auxiliary members that they should take active roles in shaping government: "You can't beat personal contact." He noted that he was lucky to be close to the physicians who lived in his district, but many legislators never heard from physicians. These same legislators, Riffe indicated, need help and input from their constituents to keep up with legislative ideas.

Speaker Riffe reminded the Auxiliary that the political stance of a legislator is not as important as the fact that he enacts legislation. This fact must be uppermost in the mind of any constituent trying to have his views heard.

Since the OSMA is a trade association, the Auxiliary members were interested in the Speaker's feeling that the Legislature probably could not function without lobbyists. He indicated that much information comes to the legislator through the input of the lobbyist. In addition, Speaker Riffe noted that any accomplishment of a lobbyist was directly related to the amount of input given him by the members of the association he represents.

Speaker Riffe concluded his remarks with some final advice: "Government is only as bad as people will stand for. Remember, you get out of government what you give to it."

(continued on page 266)

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LEFT COLUMN: Upper— Rep. Thomas J. Carney (D-Youngstown); Middle— Walter D. McClaskey (R-Marion); Lower— Rep. Ronald H. James (D-Proctorville). RIGHT COLUMN: Upper Rep. Robert A. Nader (D-Warren); Middle President Pro Tempore of the Senate Oliver Ocasek (D-Akron); Lower— Rep. Waldo Bennett Rose (R-Lima).

egislature













LEFT COLUMN: Upper— Sen. Robert E. O'Shaughnessy (D-Columbus); Middle— Rep. Terry M. Tranter (D-Cincinnati); Lower— Speaker of the House of Representatives Vernal G. Riffe, Jr. (D-New Boston). **RIGHT COLUMN:** Upper— Rep. Leslie Brown (D-Columbus); Middle— Rep. Larry H. Christman (D-Englewood); Lower— Rep. Marie Tansey (R-Vermillion) on the left and Rep. Frederick H. Deering (D-Monroeville) on the right.



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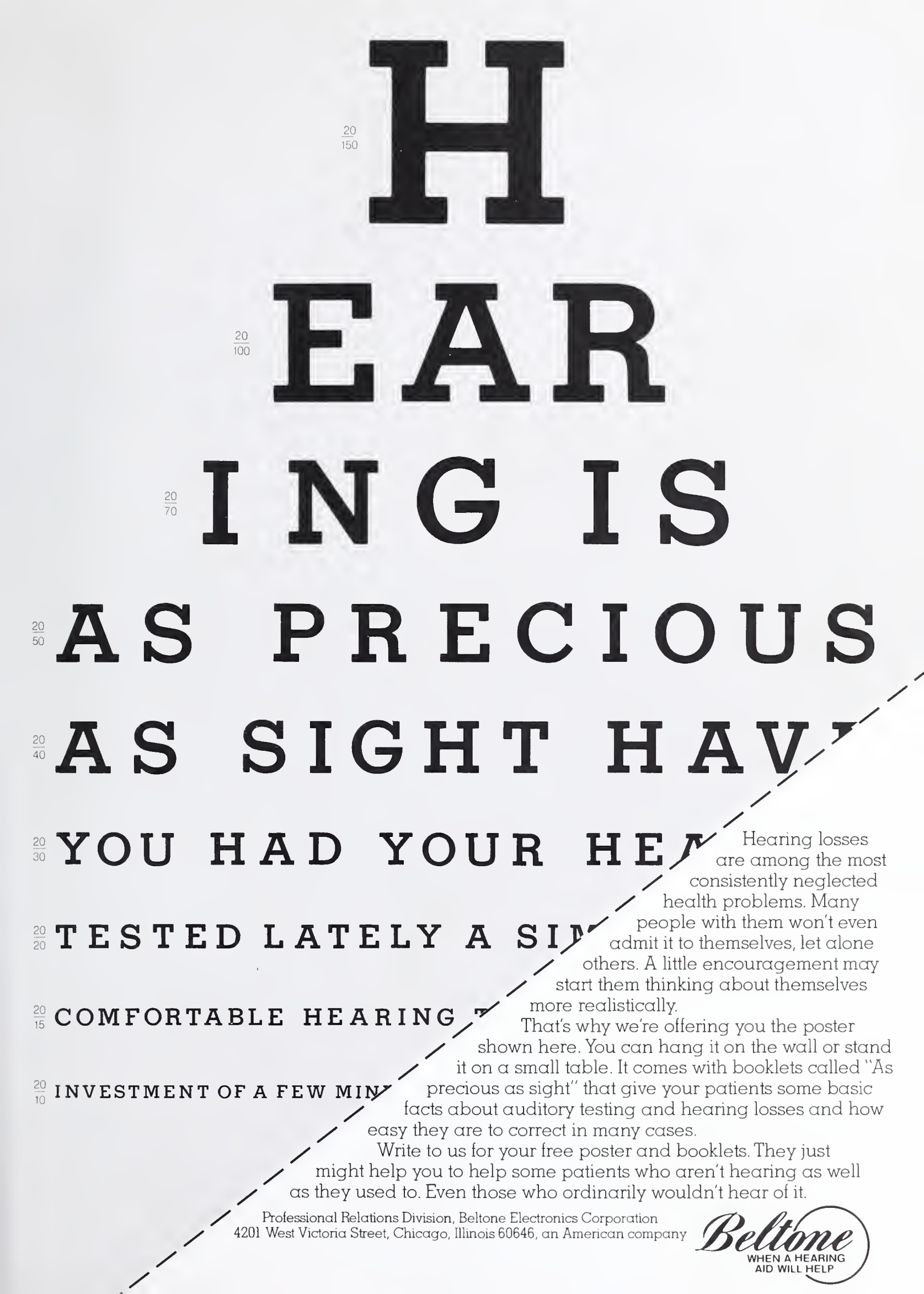
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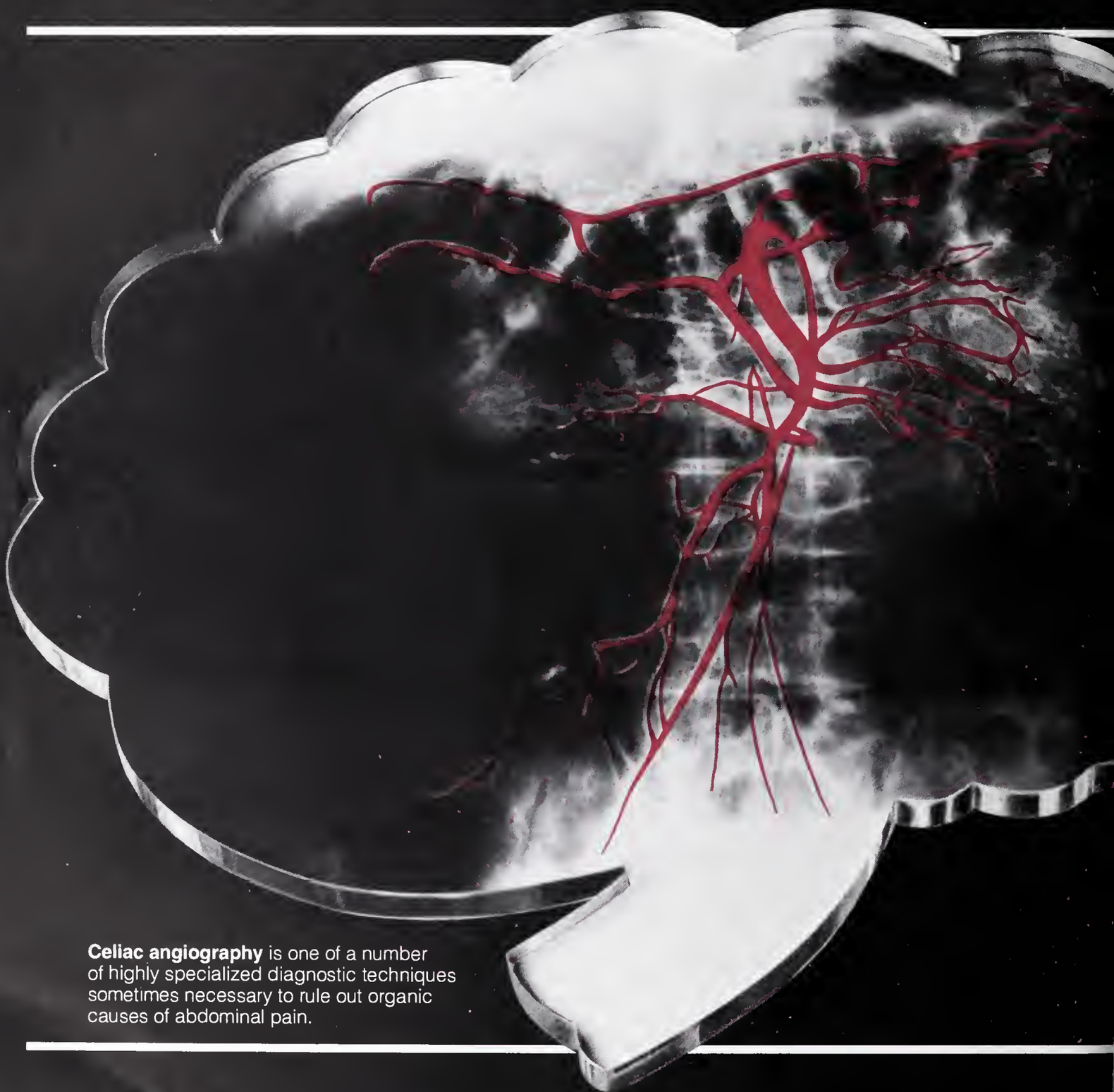
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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacolcgic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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THE OHIO STATE Medical Association News

AMA Reports on Physician Advertising

The ads promise exciting, fun-filled lives following hair transplants, face and body alteration, or wrinkle removal. Credit terms of up to 100 percent financing are offered. Major credit cards are deemed acceptable payment, and an income tax deduction is assured.

"We put it all together at our new Cosmetic Surgery Center," one group's ad boasts. Another advises that "Typically, a patient's total time at the center, from admission through recovery, is approximately six hours."

Physician advertising has been rare. But with the Federal Trade Commission issuing a complaint against the American Medical Association— that its ethical restraints on advertising are anti-competitive— the strictures are loosening.

And what sort of advertising seems to be the result? Indications are that few pediatricians are announcing office visits for $6 rather than $8. Nor are obstetricians suggesting that their fees for prenatal care and delivery are particularly reasonable. Price competition has scarcely appeared in M.D. ads to date.

The trend seems in another direction: toward what Madison Avenue calls market expansion ads. A sampling of Miami and Los Angeles newspapers turns up ads that simply encourage more people to use more medical services. Such advertising serves mainly to drive the nation's high total medical bill even higher.

"What we are beginning to see," says the AMA's Executive Vice President James H. Sammons, M.D., "is hucksterism. And I don't think hucksterism has a place in medicine.

"By that I mean solicitation," says Dr. Sammons. "Solicitation includes attempting to entice patients by use of testimonials, implying that the physicians offering these services have superior skills. Through an appeal to vanity, people are lured into expecting marvelous results. Solicitation promises that the means to the coveted end is free of risk when there is risk in virtually every medical procedure."

According to AMA guidelines, however, it is ethical for a physician to make information or intention known to the public. Doctors may furnish such information as their names, type of practice or specialties, office location and hours, even their basic fee structure to help persons make an informed choice when seeking a physician.

But according to the AMA Judicial Council, physicians "should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public."

Max Parrott, M.D., Immediate Past President of the AMA, described the philosophy behind the original ban on solicitation by the founders of the Association back in 1847: "The action was taken to avoid the implicit warranty associated with blatant advertising— the sort that used to be associated with peddling of snake oil and other 'miraculous' cures. So complex is the human mechanism that any such offer of warranty is in itself a lie, and unethical."

In December of 1975, the Federal Trade Commission filed suit against the AMA, charging that the Association's Principles of Medical Ethics prohibited doctors from generating business by advertising, price competition and competitive practices resulting in restraint of trade. An FTC trial is scheduled for September 1977. In January of this year, the AMA asked the FTC to reconsider the complaint, pointing out that while solicitation is forbidden, the AMA does permit advertising.

"In our request that the complaint be reconsidered," says Dr. Sammons, "we pointed out that we have been forced to engage in litigation to defend statements that do not even reflect current policy."

(News continued on page 350)

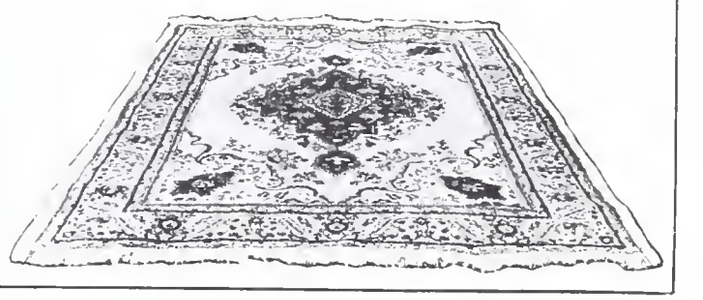
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OHIO Medical Association Medical School Highlights

A New Concept in Medical Education

The Development of Wright State University School of Medicine

W. J. Lewis, M.D.

As a practicing physician in Dayton for the past 25 years, I have watched medical training in the State of Ohio evolve into the current six medical schools and one osteopathic medical school. My interest in medical education deepened because of my involvement with Wright State University School of Medicine, one of the newest institutions for the training of physicians both locally and nationally. I have had the good fortune to be a part of the development of this Dayton institution from the outset.

Now accredited and with its first class in attendance, Wright State University School of Medicine is being maintained, as it was established, by the combined efforts of the community and the school's staff. Most of the community input comes from practicing physicians.

When mandated by legislation, Wright State was directed to emphasize primary care education. A similar mandate spawned Northeastern Ohio Universities School of Medicine. Because of this charge, Wright State draws heavily upon practicing physicians in the Dayton area for curriculum development and, ultimately, for curriculum instruction.

It is the story of the practicing physician and how he built a medical school that I propose to tell.

In the fall of 1976, Wright State University School of Medicine presented its first medical class to the community at a convocation. Thirty-two students, selected from 2,865 who made applications, rose as John R. Beljan, M.D., dean of the medical school, called their names. These students, according to Dean Baljan, were to be a new breed of physician geared to social need and conscience as well as being highly trained in the traditional arts and skills of medicine.

These young people have now almost completed the first year of their four-year medical curriculum. This curriculum is much different than that which I studied, both in content and in presentation. Possibly the greatest difference is the desire expressed in the curriculum to integrate the student with the community, the practicing physician with the full-time faculty, the practicing physician with the student, and the full-time faculty with the community.

Wright State University School of Medicine has three institutional objectives: quality education for primary care medicine, research programs related to primary care medicine, and programs of lifelong learning through continuing medical education. According to Dean Beljan, long-term planning indicates maintenance of these objectives.

Every department within the school began as a steering committee charged with development along the lines of the institutional objectives. Each of these committees was appointed by Dean Baljan, and I had the honor of being a member of the Steering Committee for Family Practice. Among the duties of a steering committee was the organization of the department including the selection of the chairman. Once the chairman had been selected, the committee continued its efforts by working with him to define goals for the department, as well as to grade and to rank volunteer faculty.

Douglas P. Longenecker, M.D., Chairman of the Wright State University School of Medicine Department of Family Practice, was the first clinical department head appointed at the school. This early appointment translated into action the emphasis on primary care education at Wright State. Dr. Longenecker has said that the greatest benefit of the steering committee has been emotional support. According to Dr. Longenecker, the committee was an excellent sounding board. In addition, the use of a committee of practicing physicians provided initial integration of community and academic ideas. This interaction, which often resulted in compromise, is the foundation for the premise that community involvement is necessary to achieve the institutional objectives of Wright State.

Once the Wright State University School of Medicine Department of Family Practice was an entity unto itself, the steering committee became the Advisory Committee to the Department of Family Practice.

Currently, Wright State University School of Medicine has a full-time faculty of 100 and well over 500 area physicians on its voluntary faculty. These participants

(continued on page 276)

Dr. Lewis, Dayton, Staff Member, Kettering Memorial and Miami Valley Hospitals; Clinical Professor of Family Practice, Wright State University School of Medicine; and Second District Councilor, Ohio State Medical Association.

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A New Concept *(continued)*

in education are looked upon as one faculty. Every department has a mix of voluntary and full-time people who share the academic goals. Research grants are not limited to full-time faculty, and continuing medical education programs are run by a variety of faculty members. Although students as yet have only had limited access to clinical training, full-time and voluntary personnel will share clinical and classroom instruction.

The bylaws of the school of medicine are unique in that they reflect the concept of one faculty. First of all, "tenure" granted full-time faculty is for a period of time, not for life as in traditional schools. Review of a faculty member occurs during his third and fifth years at Wright State, and every fifth year thereafter. This "tenure" ensures that personnel will continue to be current and relevant in their teaching methods. Second, voluntary faculty members have equal voting privileges at all faculty meetings. These meetings are held at times convenient to full-time and voluntary faculty to encourage participation by all. And third, standing committees have designated spots for voluntary faculty so that their opinions will be heard at all times.

Practicing physicians will teach what they do. All voluntary faculty have been involved in faculty development workshops which stress educational objectives, techniques of education, and outcome evaluation. Also, a series of monthly forums have been offered to the faculty. These programs are geared to dissecting a medical school's operation including financing, capital construction, and core curriculum. These programs are not required of the voluntary faculty, but participation is high. A participant is given credit toward the 100 hours each must give the school yearly in order to maintain his clinical or adjunct appointment.

I must commend those Dayton-area practicing physicians who have become members of the voluntary faculty. Not only are these physicians giving up so-called "free" time; but in order to teach well, the physician will have to slow his normal day's pace. This is asking an even further sacrifice of productive time.

Dr. Longenecker is now readying his clinical teaching program. The Department of Family Practice will make significant use of private offices, residencies, and geriatric institutions for clinical training. Practicing physicians participating in the teaching program will be instructed how to incorporate students in their practices and how to evaluate the competency and progress of students. The Family Practice Department has been given responsibility for developing a number of required courses to be completed by the student during his first three years at Wright State. This is unusual in that traditional medical schools usually assign Family Practice elective-course responsibility only. One specific course that the Family Practice faculty is coordinating on is "Introduction to Clinical Medicine" offered during the first and second years.

The fact that Dayton has numerous major health care institutions but no university hospital should insure that students will be trained in the environment of normal primary care practice. The question naturally arises that with the emphasis on primary care, will the student be exposed to the more esoteric diseases that one sees in a tertiary care center. Fortunately, among the voluntary and full-time faculty, all of the specialties as well as the various subspecialties are ably represented so that each student will indeed see his share of "zebras." Therefore, this very important aspect of his medical education will not be neglected.

Dr. Longenecker has expressed his personal philosophy about education at Wright State. "If," he said, "Wright State can mature to graduating 100 students per year with 75 percent of these entering primary care medicine, we will have accomplished our goal,"

From my own personal viewpoint as a family practitioner, I am pleased that the student is receiving early exposure to primary care. Until now, neither the student nor the resident usually saw this type of physician in action; and it was often with apology that he chose to enter the primary care ranks.

Obviously, any educational program has both strengths and weaknesses. Dean Beljan believes that the strengths of Wright State University School of Medicine far outweigh the weaknesses.

Weaknesses of the educational concept being practiced at Wright State center on the problems associated with a decentralized operation. Department chairmen are headquartered in the various community hospitals. Communication is more difficult, expenses for such items as travel are higher, and faculty encounter nonproductive time during travel from institution to institution.

Primary among the strengths is the widespread and very real community support which emanates from the practicing physician and the lay person alike. This support enabled Wright State to develop high quality programs at relatively little capital expense. Such development resulted in rapid accreditation for the school. Also, the fine quality of the health care institutions in the area provides a basis from which to build a strong clinical program. Dean Beljan stresses the unique arrangement that the school has with Wright Patterson Air Force Base. This one-of-a-kind relationship allows the Base to totally integrate with Wright State, as would any other affiliated hospital.

What is most clear in these strengths is that since students are taught in the environment in which medicine is practiced, the emphasis placed on primary care education is quite meaningful.

The program also is strong because area physicians see the school positively. They are stimulated by the students, and the advent of students into patient care in the area should improve the level of care. Because the school operates on the philosophy of integration of practicing and full-time faculty members, many problems that might occur are caught in early stages. For example,

(continued on page 278)

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SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

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1. Russek HI: AM J M Sc 239:478, 1960



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A New Concept *(continued)*

Dean Beljan is an ex-officio member of the Executive Committee of the Montgomery County Medical Society; two practicing physicians sit on the committee that judges faculty promotions; and community members are active in the admissions program.

Wright State University School of Medicine is pioneering the concept of primary care education. In doing so, the school of medicine has become a community effort. During the first convocation, the close ties between Wright State University School of Medicine and the community were emphasized. Robert J. Kegerreis, Ph.D., President of Wright State University, noted that it had long been the dream of the Dayton area to have a medical school. More than 16 years prior to the 1976 convocation, community leaders attempted to establish such a school. Dr. Kegerreis gave credit to the legislative and political leaders, the hospital administrators, and the physicians of the Dayton area for their influence in the birth of the medical school.

The presence at the convocation of then-president of the Montgomery County Medical Society, John Worthman, M.D., bespoke the intertwining of school and community efforts. And Dr. Beljan's remark: "One of the privileges of the position of dean is to work with the practicing physician," warmed the hearts of physician and patient alike in attendance.

Anyone who feels there are no problems now or in the future in the development of a medical school is naïve. In ten years, will this be a traditional medical school? Will the concept on which it is built be valid? No one, of course, knows. To me, however, it is a once-in-a-lifetime opportunity to participate in a unique experiment based upon principles in which I believe. It is incumbant upon all members of the medical community to involve themselves so that the concept is fairly tried and does not lose by default.

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Saturday, June 18, 8:00–11:00 AM–2:00–5:00 PM
(6-hour, 1-day courses: $60)

SF-1. Acid-Base, Fluids, & Electrolytes
SF-2. Echocardiography: Basic Concepts
SF-3. Cutaneous Surgery for the Dermatologist
SF-4. How to Sew (Principles of Suture Technique)
SF-5. Office Gynecology
SF-6. Understanding & Managing Mid-Career Crises for Physicians
SF-7. New Developments in the Treatment of Stroke
SF-8. ENT Emergencies for the Practicing Physician
SF-9. Eye Problems for the Nonophthalmologist
SF-10. Writing for Scientific Journals
SF-11. Update on Practical Antibiotic Therapy
SF-12. Current Techniques in Cardiovascular Nuclear Medicine
SF-73. Cosmetics in Dermatology

Saturday, June 18, 7:30 AM–Noon
(5-hour course: $50)

SF-13. Basic Life Support—Cardiopulmonary Resuscitation (CPR)

Saturday, June 18, 1:00-5:30 PM
(5-hour course: $50)

SF-14. Basic Life Support—Cardiopulmonary Resuscitation (CPR)

Saturday, June 18, 9:00 AM–Noon–1:00–5:00 PM &
Sunday, June 19, 9:00 AM-Noon
(11-hour, 2-day course: $130)

SF-15. Public Speaking Seminar

Saturday, June 18, 8:00-11:00 AM
(3-hour course: $30)

SF-16. Interpretation of Chest Roentgenograms

Saturday, June 18, 2:00-5:00 PM
(3-hour course: $30)

SF-17. Clinical Electromyography for the Referring Physician

Sunday, June 19, 8:00–11:00 AM–2:00–5:00 PM
(6-hour, 1-day courses: $60)

SF-18. Electrocardiography: Basic Concepts
SF-19. Diagnosis & Management of Cardiac Arrhythmias
SF-47. Dermatology for Nondermatologists
SF-21. Antibiotic Usage in Pediatrics
SF-22. Primary Treatment of Injuries of the Hand
SF-23. Gynecologic Endocrinology
SF-24. Exercise in the Diagnosis, Prevention, & Rehabilitation of Ischemic Heart Disease
SF-25. Therapy of Sexual Dysfunctions & Disorders
SF-26. Current Bedside Clinics in Neurology

Sunday, June 19, 7:30 AM–Noon–1:00–5:30 PM &
Monday, June 20, 7:30 AM-Noon
(12-hour, 2-day course: $120)

SF-27. Advanced Life Support—Cardiopulmonary Resuscitation (CPR), Prerequisite: Basic Life Support course; *Required Reading: CPR Advanced Life Support Text* 70034B, $7.50; order through American Heart Association, 7320 Greenville Ave., Dallas, Tex. 75231—make check payable to: American Heart Association

Sunday, June 19, 8:00-11:00 AM
(3-hour courses: $30)

SF-28. Liver Disease—New Developments
SF-29. Useful Diagnostic Laboratory Tests in Endocrine Disease
SF-32. Refresher Course in Dermatopathology
SF-70. Diagnosis & Treatment of Fractures of the Lower Extremities

Sunday, June 19, 2:00-5:00 PM
(3-hour course: $30)

SF-20. Live Case Presentations for Dermatologists
SF-30. Useful Diagnostic Laboratory Tests in Endocrine Disease

Monday, June 20, 8:00–11:00 AM–2:00–5:00 PM & Tuesday, June 21, 8:00–11:00 AM–2:00 to 5:00 PM (12-hour, 2-day course: $120)

SF-31. Practical Exercises in Emergency Care

Monday, June 20, 8:00–11:00 AM–2:00–5:00 PM (6-hour, 1-day courses: $60)

SF-33. How to Sew (Principles of Suture Technique)
SF-34. Problem Care Seminar on Common Hand Injuries: Basic & Advanced Techniques
SF-35. Respiratory Emergencies in Children
SF-36. Critical Injuries: Recognition & Early Treatment
SF-37. Evaluation & Management of Respiratory Failure
SF-38. Spine & Spinal Cord Injuries: An Update for Primary Care Physicians
SF-39. Peptic Ulcer
SF-40. Diabetes
SF-41. Practice Management Seminar
SF-42. An Overview of Current Psychotropic Drugs

Monday, June 20, 8:00–11:00 AM (3-hour course: $30)

SF-44. Management of Convulsive Disorders: "Fits Are Old—Not So Appraisal or Treatment"
SF-71. Diagnosis & Treatment of Fractures, Dislocations, & Epiphyseal Injuries in Children

Monday, June 20, 1:00-5:30 PM (5-hour course: $50)

SF-43. Basic Life Support—Cardiopulmonary Resuscitation (CPR)

Tuesday, June 21, 8:00–11:00 AM–2:00–5:00 PM (6-hour, 1-day courses: $60)

SF-45. Acid-Base, Fluids, & Electrolytes
SF-46. Echocardiography: Basic Concepts
SF-48. Some Things Old & Some Things New in the Treatment of Rheumatic Diseases
SF-49. New Drugs in Gastroenterology
SF-50. Urologic Pathology
SF-52. Hypertension 1977: A Practical Approach to the Evaluation & Management
SF-53. Common Errors in Emergency Wound Management: Basic & Advanced Techniques
SF-54. Complete Management of Pulmonary Neoplasms
SF-55. Office & Hospital Management of Anorectal Disease

Tuesday, June 21, 7:30 AM–Noon–1:00–5:30 PM & Wednesday, June 22, 7:30 AM-Noon (12-hour, 2-day course: $120)

SF-56. Advanced Life Support—Cardiopulmonary Resuscitation (CPR), Prerequisite: Basic Life Support course; see SF-27 for required reading

Tuesday, June 21, 8:00–11:00 AM (3-hour course: $30)

SF-51. CT Scanning & Neurological Diagnosis: "New Views of the Old Head"
SF-72. Diagnosis & Treatment of Fractures of the Upper Extremities

Tuesday, June 21, 2:00–5:00 PM (3-hour courses: $30)

SF-57. Biofeedback in Muscle Re-Education & Relaxation
SF-58. Toward More Appropriate Utilization of Laboratory Tests: Maximizing Clinical Information from Laboratory Tests

Wednesday, June 22, 8:00 AM–Noon–2:00–5:00 PM (6-hour, 1-day courses: $60)

SF-59. Electrocardiography: Basic Concepts
SF-60. Diagnosis & Management of Cardiac Arrhythmias
SF-61. Pediatric Dermatology
SF-62. Recent Advances in GI Surgery
SF-64. Diagnosis & Therapy of Common Renal Diseases
SF-65. Office Orthopedics for the Nonorthopedist
SF-66. Drug Interactions Relevant to the Primary Care Physician
SF-67. Practical Office & Laboratory Procedures in Allergic Disease

Wednesday, June 22, 8:00–11:00 AM (3-hour course: $30)

SF-63. On Understanding & Treating Dizziness
SF-69. Office Urology

Wednesday, June 22, 1:00–5:30 PM (5-hour course: $50)

SF-68. Basic Life Support—Cardiopulmonary Resuscitation (CPR)

Registration Form

AMA's 126th Annual Convention/San Francisco/ June 18-22, 1977

Please print and return to:

AMA Dept. of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610; or phone: (312) 751-6503.

I am a member of the AMA through the following state medical association: . If you are not an AMA member, please add $35 to your total remittance. ($35 fee does not apply to medical students or residents.) Payment must accompany choice of courses (where fees are required) on this registration form.

Advance Registration. To receive your Advance Registration Card, this form must arrive at the AMA by May 20, 1977. (After this date, please register at Brooks Hall CME Registration Desk, San Francisco, California Your Advance Registration Card will be sent to you on May 27, 1977, unless you request an earlier mailing date.

General Registration. AMA members and their guests, no fee. Nonmember physicians, $35; their guests, $10 per person. Medical students, residents, and Canadian and other foreign physicians, no fee. (Does not include CME course fees.)

CME Course Registration. Please Note: Fee schedule for each item. Insert course numbers of your choice for each day and indicate your order of preference in the space provided. If minimum registration is not attained for your first choice, your alternate choice will be substituted. The course numbers correspond to the listing and fees shown.

All medical students and residents are entitled to a 50% discount on course registration fees ($10 per credit hour is standard rate). Payment must accompany choice of courses requested on this registration form.

Date		Course No.	Fee	Course No.
Sat.	AM	1st Choice	$	2nd Choice
June 18	PM	1st Choice	$	2nd Choice
Sun.	AM	1st Choice	$	2nd Choice
June 19	PM	1st Choice	$	2nd Choice
Mon.	AM	1st Choice	$	2nd Choice
June 20	PM	1st Choice	$	2nd Choice
Tues.	AM	1st Choice	$	2nd Choice
June 21	PM	1st Choice	$	2nd Choice
Wed.	AM	1st Choice	$	2nd Choice
June 22	PM	1st Choice	$	2nd Choice
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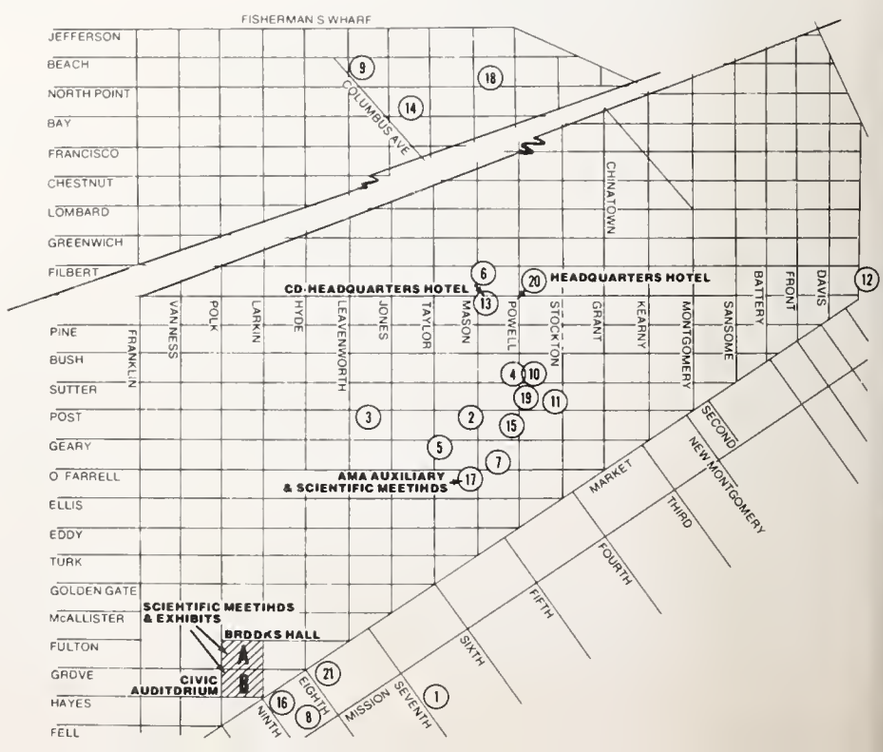
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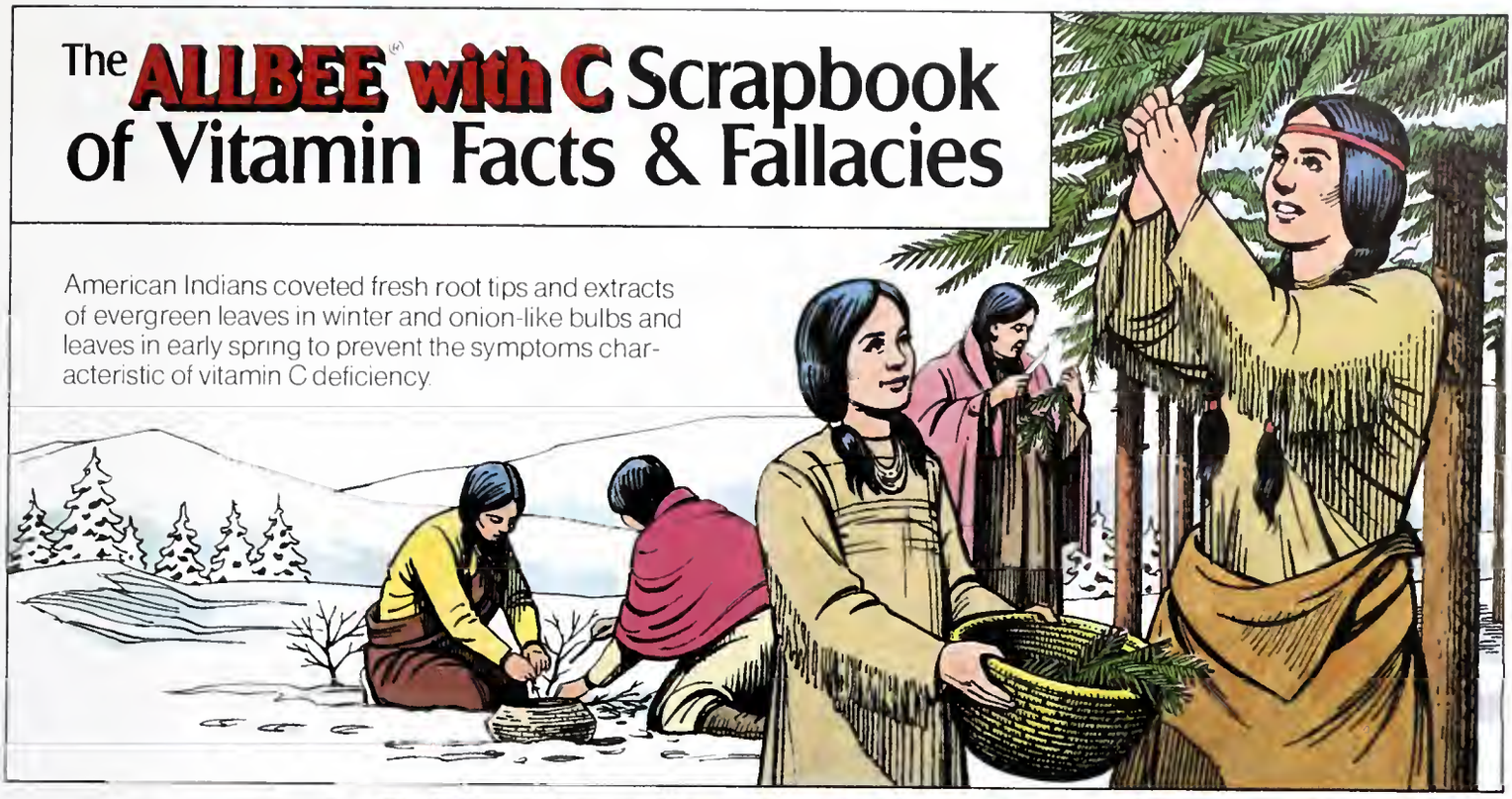
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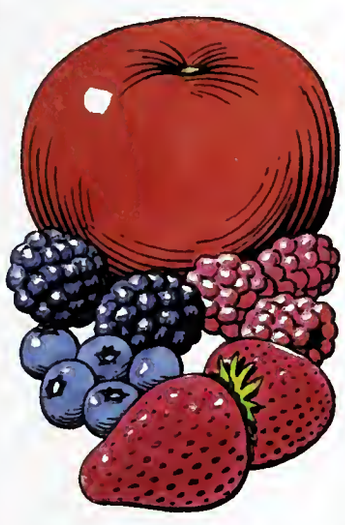
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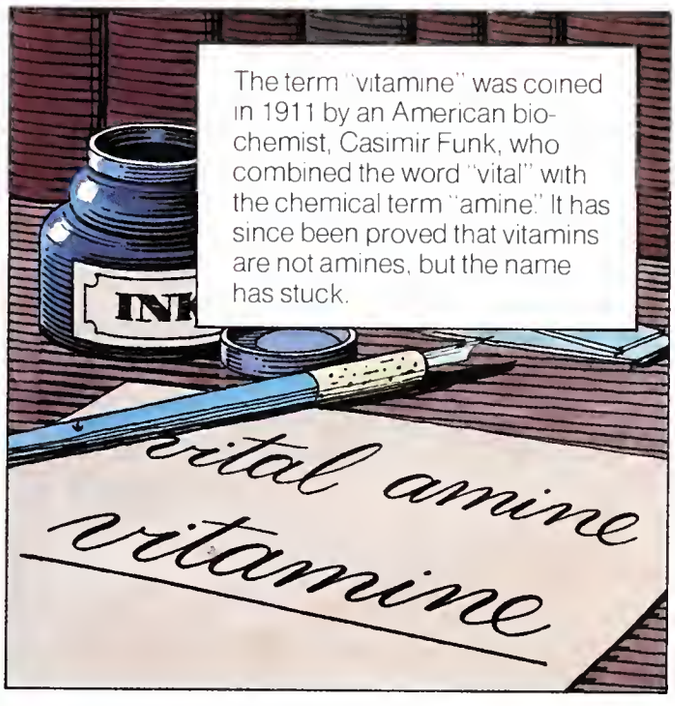




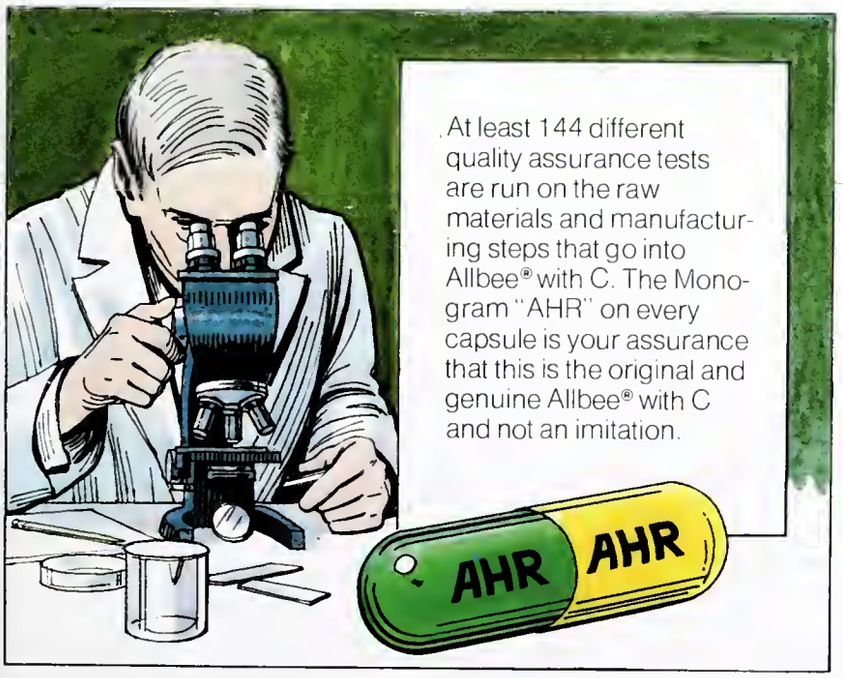
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An Update on the

Medical Professional Liability Insurance Market

*Linda A. Jacobson**

Since July 1975, the medical professional liability insurance market in Ohio has altered dramatically. Until July 1975, there was growing concern that the professional liability insurance market for physicians would literally "dry up" within a short period of time. With many carriers either withdrawing or threatening to withdraw from the market, the Ohio General Assembly enacted Amended Substitute House Bill 682, the Omnibus Malpractice Act, which became effective on July 28, 1975. One of the results of this bill was the formation of the Joint Underwriting Association (JUA), a non-profit unincorporated association which was to provide professional liability insurance for physicians and hospitals.

Over the ensuing months, many private insurance carriers did, in fact, withdraw from the Ohio market. But, as was not anticipated in July 1975, single-line companies offering liability insurance to Ohio physicians have entered the Ohio market.

With such a diverse market, it is important that the physician purchasing professional liability coverage clearly understand the options open to him when selecting insurance. In addition to the JUA, insurance companies offering medical professional liability insurance in Ohio fall into these categories: mutual, reciprocal, and stock.

It is the purpose of this article to explain the benefits and risks a physician may expect if he purchases professional liability coverage from one of these four types of insurance carriers.

Mutual

Mutual insurance companies are of two types: participating and non-participating. The least amount of financial risk to a physician policyholder is the non-participating form which only calls for an investment in the amount of the physician's policy premium.

Should the liabilities of a non-participating mutual exceed the company's assets, the company would be declared insolvent. At such time, the Ohio Insurance Guaranty Association would take over payments of claims and defense costs (including the cost of providing defense counsel) incurred with respect to current or future claims and suits brought against physicians insured by the insolvent company.

The Ohio Insurance Guaranty Association was established September 4, 1970 by the Ohio General Assembly. Its purpose is to handle the liabilities of domestic or foreign insurance companies doing business in Ohio which a court of competent jurisdiction declares to be insolvent and orders to be liquidated.

The Association is funded by assessing each Ohio carrier writing that type of liability insurance in proportion to the assessed company's percentage of the Ohio business. (This assessment cannot exceed 2½ percent of the assessed company's Ohio premium income.) The assessed company is then required to pay the Association this percentage of the monies needed to cover claims against the insolvent company. The Association reimburses the assessed company with monies collected from the liquidated company's assets, if any.

The Ohio Guaranty Association assures all physicians who insure with companies covered by the Association that they will not be individually liable for claims made against the company should the company become insolvent.

Physicians insuring with a participating mutual have contingent liability in the form of an assessable policy, such assessments to be implemented in the same way as with a reciprocal. (See Reciprocal.) However, the assessability would only be for the policy period. If a mutual issues an assessable policy, this fact would be expressly indicated in the terms and conditions of the policy. As a practical matter, mutuals do not issue assessable policies as they would not be saleable in today's insurance market.

Reciprocal

Physicians purchasing liability insurance from companies classified as reciprocals initially incur the financial cost of their premiums. However, because members of a reciprocal are fully assessable (except as indicated hereafter) actual premium dollars paid may not reflect the dollars needed to operate the reciprocal. These additional monies needed to operate the reciprocal will be paid by those insuring with the reciprocal.

Assessability means that whenever more dollars are needed to operate the company (ie, to defend and to pay claims) each member of the company is required by law to pay a percentage of the total amount of money needed. This percentage is computed by dividing the physician's liability insurance premium by the total of all premiums collected by the company.

Members of a reciprocal are fully assessable for as long as they are actively practicing medicine. Should a physician discontinue buying liability insurance from the reciprocal but remain in active practice, he will be fully assessable for any claims arising out of the period

(continued on page 288)

*The author wishes to thank James F. Mosier, Esq., Assistant Director of the Ohio Department of Insurance, who supplied much of the information for this article.

of time he was a member of the reciprocal. (In the case of one reciprocal now operating in the Ohio market, its attorney-in-fact has stated that, although the reciprocal's policies are fully assessable, future assessments are regarded as a possibility and not a probability. The Ohio Department of Insurance has approved the reciprocal's bylaw amendment which frees members or former members from assessability in the event of death, total disability, or retirement.)

It should be noted that a member or ex-member of a reciprocal will be assessed not only for monies needed to defend and to pay claims against him, but also for claims against any other member of the reciprocal. Should a member or ex-member not be able to pay his assessment by reason of insolvency, death, retirement, or total disability, his share must be paid by the remaining members of the reciprocal.

Assessability is exceedingly important because a medical malpractice reciprocal insurance company is not covered by the Ohio Insurance Guaranty Association. Therefore, whenever claims exceed the surplus of a reciprocal, the individual members of the reciprocal are held financially responsible for the cost of defending and paying those claims.

A physician insuring with a reciprocal must be aware that, as long as he continues in active practice, he faces financial liability through potential future assessments for any claims the company cannot meet which arise out of the period he was a member of the reciprocal.

The reciprocal is the only type of medical professional liability insurance company in which a physician is financially liable and at risk from the time he enters the reciprocal until he either dies, retires, or becomes totally disabled.

Residual (Non-Voluntary)

The Joint Underwriting Association (JUA) was created as a source of medical professional liability insurance for physicians who, for one reason or another, were having difficulty securing insurance in the voluntary market. However, physicians insuring with the JUA must meet minimum underwriting standards.

Cost in the JUA begins with the premium. Additionally, physicians purchasing insurance with the JUA must also make a "surcharge" payment equal to 100 percent of their primary policy premium (not to exceed $5,000) to the Stabilization Reserve Fund (SRF). Purchase of excess coverage necessitates a further payment of 25 percent of the premium (up to a maximum of $750) to the SRF. If a physician purchases both types of insurance from the JUA, his surcharge payment to the SRF is limited to his primary coverage.

It should be noted that physicians insuring with any other companies must pay $250 per policy to the Stabilization Reserve Fund. Therefore, purchase of primary coverage from the voluntary market and excess from the JUA requires surcharge payments to the SRF on both premiums.

The Stabilization Reserve Fund provides a fund to reimburse the JUA should the JUA premium dollars be exceeded by claims and expenses, thereby creating a deficit. Physicians purchasing insurance from the JUA have no personal financial risk should the SRF be exhausted and claims liability be in excess of $1 million. However, the Ohio Department of Insurance may impose a surcharge on each insurance company writing medical malpractice insurance in Ohio. This surcharge could result in physicians insured by the companies having to pay an assessment (maximum: $1,000 per year per physician) which will be used to cover the deficit.

Finally, because the JUA offers only a "claims-made" policy, the physician has more premium expense should he wish to discontinue his JUA coverage. He must buy "tail" coverage or a reporting endorsement in order to cover claims not yet reported but arising out of his acts or omissions during the JUA policy period. This "tail" coverage becomes increasingly more expensive the longer the physician remains insured with the JUA. The "tail" coverage becomes necessary as a practical matter if a physician leaves any company offering a "claims-made" professional liability insurance policy.

Stock

A stock company places no contingent fanancial liability upon the policyholder. This situation arises from the fact that a physician who purchases insurance from a stock company is not assessable. Should the company's liabilities exceed assets, the Ohio Insurance Guaranty Association covers such losses. (See Mutual.)

If a stock company becomes insolvent, the physician would, at worst, lose his investment in any stock he owned in the company. If the company simply had a bad year and the physician owned common stock, he could expect the company's dividend policy to be affected accordingly. Therefore, the cost to a physician insuring with a stock company amounts to his policy premium and his stock purchase, whether mandatory or voluntary.

Conclusion

In conclusion, the Ohio medical professional liability market offers the physician several choices in the type of company with which to insure. Today's Ohio market is composed of mutual, reciprocal, residual, and stock insurance companies. Before buying a policy, the physician should become aware of all of his possible financial risks and should weigh these in making a decision as to where to place his premium dollars. If he has any questions regarding medical professional liability insurance, both the Ohio State Medical Association and the Ohio Department of Insurance are ready to provide the physician with information.

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Correlation of Bicycle Ergometry With Coronary Arteriography

Conrad Simpfendorfer, M.D.
Myron H. Luria, M.D.

Bicycle exercise testing and selective coronory arteriography were performed in 119 consecutive patients referred for evoluation of typical ongina, atypical chest poin, or abnormolities in the resting electrocardiogram (ECG). Using a criterion of >50 percent narrowing on coronory orteriogrophy, the prevalence of coronary heort diseose was 54 percent. A criterion for abnormolity of ≥1 mm ST depression gave an overall sensitivity of 36 percent, a specificity of 76 percent, a predictive value for a positive test of 64 percent, ond a predictive value for a negative test of 51 percent.

The more clinically oriented predictive volue could be improved significontly when selected subgroups were evoluoted: (1) Predictive values for a positive test between 79 ond 100 percent were obtained in men, patients who exercised at more than 600 kpm/min or had typical angino. (2) Predictive values for a negative test between 91 ond 100 percent were found in patients with a normal resting ECG who were less than 50 years old, or were women, or exercised maximally at ≥800 kpm/min, or had a maximally ottained oxygen consumption of >25 ml/kg/min. (3) The predictive value of a negotive test in patients with atypical angino who maximolly attained an oxygen consumption >25 ml/kg/min was 92 percent. In spite of severe limitation in sensitivity, bicycle ergometry retoins excellent correlation with coronary arteriography in selected subgroups of patients.

EXERCISE ELECTROCARDIOGRAPHY has been widely used in the evaluation of patients with suspected coronary heart disease (CHD) because it is noninvasive, easily performed, and with proper precautions, low in risk. Studies correlating exercise electrocardiography with coronary arteriography have given conflicting results regarding the reliability of exercise testing as an indicator of significant CHD.[1-10] The lack of uniform terminology and differences in the prevalence of CHD in the different populations studied have made comparison of results difficult. This study was undertaken to evaluate the sensitivity, specificity, predictive value, and efficiency of bicycle ergometry as a diagnostic method for CHD, and to compare our results with previous studies using common criteria for abnormality and similar epidemiologic terminology.

Methods

The study group consisted of 119 consecutive patients who underwent both selective coronary arteriography and bicycle ergometry between January 1975 and March 1976. Patients were referred for evaluation because of typical angina pectoris, atypical chest pain, or abnormalities in the resting electrocardiogram. Angina pectoris was characterized by all of the following three characteristics: (1) chest pain in the sternal area or left anterior chest with radiation to left arm; (2) precipitation by exertion or emotional stress; (3) relief in ten minutes by nitroglycerin or cessation of exertion. Atypical angina pectoris was diagnosed when the chest pain site was atypical or if it took longer than ten minutes for chest pain in a typical site to subside following nitroglycerin.

There were 90 men and 29 women with an age range of 23 to 67 years and a mean of 50.5 years. Excluded were patients with valvular heart disease, bundle branch block, or patients taking digitalis, propranolol, or antiarrhythmic medication. Using a CS_5 lead system (reference electrode over right subclavicular area, ex-

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Dr. Luria, Cleveland, Director, Division of Cardiology, Saint Luke's Hospital; and Assistant Professor of Medicine, Case Western Reserve University School of Medicine.
Submitted October 8, 1976.

ploring electrode at V_5), patients were exercised on either a variable-load (Monark*) or a constant-load bicycle ergometer (Quinton†). Work loads were measured in kilopond-meter/minute (kpm/min). Nine percent was added to patients exercised on the variable-load bicycle to compensate for chain traction. Patients were exercised at a given level for five minutes followed by a four-minute resting period before increasing the work load by 164 to 200 kpm/min. Exercise was continued until severe chest pain, frequent ventricular ectopic beats, or electrocardiographic evidence of injury developed or until exhaustion precluded further testing. Tracings were recorded every minute during and after exercise. The patients' expired air was collected and analyzed for calculation of maximally attained oxygen consumption using Parkinson-Cowan spirometer,‡ a Beckman LB-2 medical gas analyzer for carbon dioxide and oxygen analyzer OM-11.§ Ninety-seven patients had satisfactory collections for calculation of oxygen consumption.

The exercise electrocardiogram was considered positive if a horizontal or downward-sloping ST segment was depressed 1 mm or more, 0.08 seconds after the J point. Coronary arteriography was performed by the Sones or Judkins technique, and all cineangiograms were evaluated by two different observers. Greater than 50 percent obstruction of a major coronary vessel was considered significant. Definitions and abbrevations used to define the accuracy of bicycle ergometry are given in Table 1.

TABLE 1. Definitions and Abbreviations for Defining Accuracy of Bicycle Ergometry

Sensitivity	=	$\frac{TP}{TP + FN} \times 100$
Specificity	=	$\frac{TN}{FP + TN} \times 100$
Predictive Value of Positive Test	=	$\frac{TP}{TP + FP} \times 100$
Predictive Value of Negative Test	=	$\frac{TN}{FN + TN} \times 100$
Efficiency	=	$\frac{TP + TN}{TP + FP + TN + FN} \times 100$

TP=true positive TN=true negative FP=false positive
FN=false negative
Sensitivity=frequency of positive test results in patients with CHD
Specificity=frequency of negative test results in patients without CHD
Predictive value of positive test=percent of patients with positive test who have CHD
Predictive value of negative test=percent of patients with negative test who do not have CHD
Efficiency=percent of patients correctly classified as having or not having CHD

Results

Clinical data on 119 patients undergoing both stress testing and coronary arteriography are listed in Table 2. The prevalence of CHD was 54 percent. Since only 23 of the 64 patients with CHD had a positive exercise test, the sensitivity was 36 percent (Table 3). Forty-two of the 55 patients without CHD had negative exercise tests and, thus, the specificity was 76 percent. Alternatively, of 36 patients with a positive exercise test, 23 had CHD resulting in a predictive value of 64 percent. Forty-two of 83 patients with a negative test did not have significant CHD, giving a predictive value for a negative exercise test of 51 percent. The overall efficiency or percent of patients correctly classified as having or not having significant CHD was 55 percent.

The same correlations were determined in a variety of patient subgroups (Table 4). The sensitivity reached a high of 50 percent in women and in patients with typical angina pectoris. The specificity was greater than 90 percent in patients who were able to exercise at more

TABLE 2. Clinical Data for 119 Patients Undergoing Both Stress Testing and Coronary Arteriography

		No CHD	With CHD
Patients		55	64
Sex:	Male	34	56
	Female	21	8
Age:		47.1 ± 8.8	53.5 ± 7.6*
Angina:	Typical	3	26
	Atypical	50	29
	None	2	9
Resting ECG:	Normal	44	20
	Old MI	3	27
	ST-T changes	8	17
Maximum heart rate		156 ± 21	143 ± 26*
Maximum kpm/min		640 ± 238	578 ± 206
Maximum O_2 consumption (ml/kg/min)		22.5 ± 7.1	19.8 ± 5.7†

CHD = coronary heart disease
MI = myocardial infarction kpm = kilopond-meter
*$p < .01$
†$p < .05$

*Cyclefabriken-Monark, Stockholm, Sweden
†Quinton Instruments, Seattle, Washington
‡Dynasciences Medical Products, Blue Bell, Pennsylvania
§Beckman Instruments Inc., Schiller Park, Illinois

than 600 kpm/min, or had a maximally attained oxygen consumption of more than 25 ml/kg/min. Patients with typical angina pectoris and those who exercised at more than 600 kpm/min had a predictive value for a positive test of 93 and 86 percent, respectively. The predictive value for a negative test was 77 percent in women, 76 percent in patients with a normal resting electrocardiogram, and 72 percent in patients less than 50 years old.

Combining two of these variables with the results of the bicycle ergometer test allowed us to define subgroups with predictive values for a positive test between 86 and 100 percent (Fig. 1) and subgroups with predictive values for a negative test between 91 and 100 percent (Fig. 2). The latter also had specificities between 80 and 100 percent.

The low sensitivity of bicycle ergometry was further demonstrated by the presence of a positive exercise test in only 5 of 15 patients with significant disease of the left anterior-descending coronary artery; one of eight patients with right coronary artery disease; and 8 of 17 patients with combined left anterior-descending, right and circumflex coronary artery disease.

Discussion

Our results point out the severe limitations in the sensitivity of bicycle ergometry as a diagnostic test for significant coronary artery disease. Table 5 compares the results of seven previous studies where it was possible to use similar criteria for abnormality and similar epidemiologic definitions. Our results are comparable to the findings of these previous investigations which, in general, confirm a low sensitivity.

Since exercise stress testing may be an indicator of the functional capacity of the entire heart rather than a specific anatomical lesion seen on coronary arteriography, a low sensitivity might not be entirely unexpected. The distinction between a test providing physiological data and a test providing anatomic localization of obstruction, therefore, may explain the absence of abnormal exercise electrocardiographic changes in patients who have complete obstruction of a coronary artery. For example, 13

TABLE 3. Correlation of Bicycle Ergometry with Coronary Arteriography in 119 Patients

Sensitivity	23/64	(36%)
Specificity	42/55	(76%)
Predictive value (+) test	23/36	(64%)
Predictive value (−) test	42/83	(51%)
Efficiency	65/119	(55%)

TABLE 4. Correlation of Bicycle Ergometry with Coronary Arteriography in Selected Patient Subgroups

Group		No. of Patients	Sensitivity %	Specificity %	Pred. Value (+) Test %	Pred. Value (−) Test %
Sex:	Men	90	34	85	79	44
	Women	29	50	62	33	77
Age:	<50 yrs	52	42	85	62	72
	>50 yrs	67	33	64	65	32
Angina:	Typical	29	50	67	93	13
	Atypical	79	37	76	48	66
	None	11	–	–	–	18
Resting ECG:	Normal	64	40	84	53	76
	Old MI	30	26	67	88	9
	ST-T Changes	25	47	38	62	25
Maximum Heart Rate:	<85%	53	36	75	71	42
	≥85%	66	35	77	58	57
Maximum Kpm/min:	≤600	64	45	54	59	40
	>600	55	23	97	86	58
Maximum 0_2 Consumption (ml/kg/min):	≤25	74	40	71	65	46
	>25	23	13	93	50	67

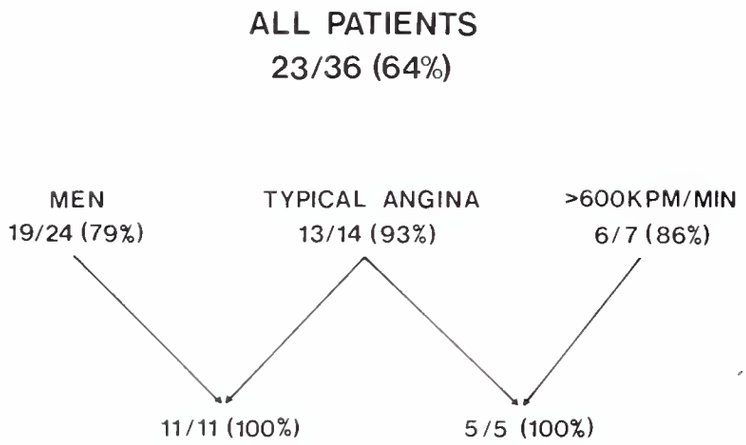


FIG. 1. Predictive value of positive exercise test. In each group, denominator indicates number of patients with positive stress test and numerator indicates patients with positive stress test with significant coronary disease. Kpm = kilopond-meter.

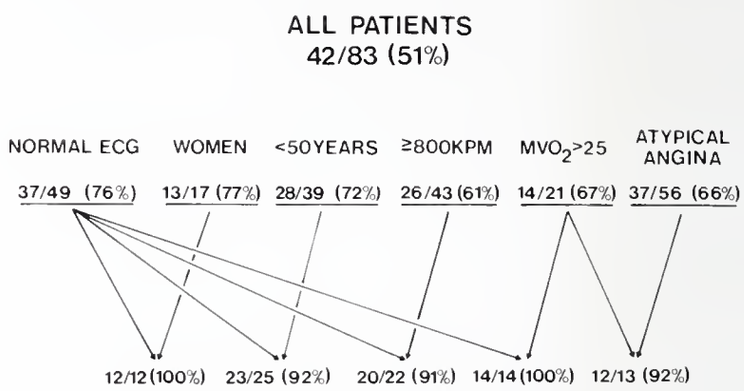


FIG. 2. Predictive value of negative exercise test. In each group, denominator indicates number of patients with negative stress test and numerator indicates patients with negative stress test without significant coronary disease. Kpm = kilopond-meter. MVO_2 = maximally attained oxygen consumption in ml/kgm/min.

of our patients had complete occlusion of one vessel without significant disease in the other two major coronary vessels. Of these patients, only two had a positive stress test (sensitivity 15 percent).

Another explanation for a low sensitivity may be that the ST segment change is not the only criterion for abnormality; if included, other findings, such as cardiac arrhythmias and inadequate heart rate and blood pressure responses, might improve the sensitivity of the test.[11] However, only one of the patients in our study was stopped because of frequent ventricular ectopic beats, and none was stopped because of a fall in heart rate or blood pressure.

Despite this low sensitivity, a consideration of predictive values offers an alternate approach for the clinician. Their calculations indicate an initial orientation toward the stress test result rather than the coronary arteriogram. Thus, if the clinician is cognizant of the exercise test results, he then will question the probability of significant occlusive disease being present or absent in the coronary arteriogram. Alternatively, the sensitivity and specificity view this relationship with an orientation based on the coronary arteriogram. The clinician, knowing the latter results, then will consider the probability of significant ST alterations being present or absent in the stress electrocardiogram. Although both approaches are important in the evaluation of a testing procedure, predictive values may have greater relevance for the clinician who wishes to employ stress testing before considering coronary arteriography.

We have identified specific subgroups of our patients where the predictive value of exercise electrocardiography

TABLE 5. Studies in Which Exercise Electrocardiography Has Been Correlated with Coronary Arteriography*

Study	No. of Patients	Prevalence of CHD %	Sensitivity %	Specificity %	Pred. Value (+) Test %	Pred. Value (−) Test %	Efficiency %
Likoff[1]	74	32	58	68	47	77	65
Kassebaum[2]	68	50	53	97	95	67	75
Mason[3]	84	58	78	89	90	74	82
Roitman[4]	46	65	80	88	92	70	83
McConahay[5]	100	65	35	100	100	46	58
Martin[7]	100	63	62	89	91	58	72
Borer[9]	89	62	49	41	57	33	46
Present study	119	54	36	76	64	51	55

*Criteria for abnormality were $\geq$1 mm ST depression and >50% coronary artery narrowing in all studies.

demonstrates an excellent correlation with coronary arteriography. The predictive value of a positive test was between 79 and 92 percent in men, patients with typical angina pectoris or those who exercised at more than 600 kpm/min. The correlation improved to 100 percent when two of the variables were combined (Fig. 1).

Alternatively, when given a negative test in patients with a normal resting ECG, the correlation with coronary arteriography was correct in 76 percent of the patients. If a second variable was added to this, ie, women, aged <50 years, maximum work ≥ 800 kpm/min or maximally attained oxygen consumption >25 ml/kg/min, the correlation was between 91 and 100 percent (Fig. 2).

Summary

Due to its severe limitation in sensitivity, bicycle ergometary is less than satisfactory when used alone as a diagnostic test for CHD. However, if the results are combined with clinical information (sex, age, symptoms) and physiologic data (work load, maximally attained oxygen consumption), a high predictive value can be attained for both positive and negative tests.

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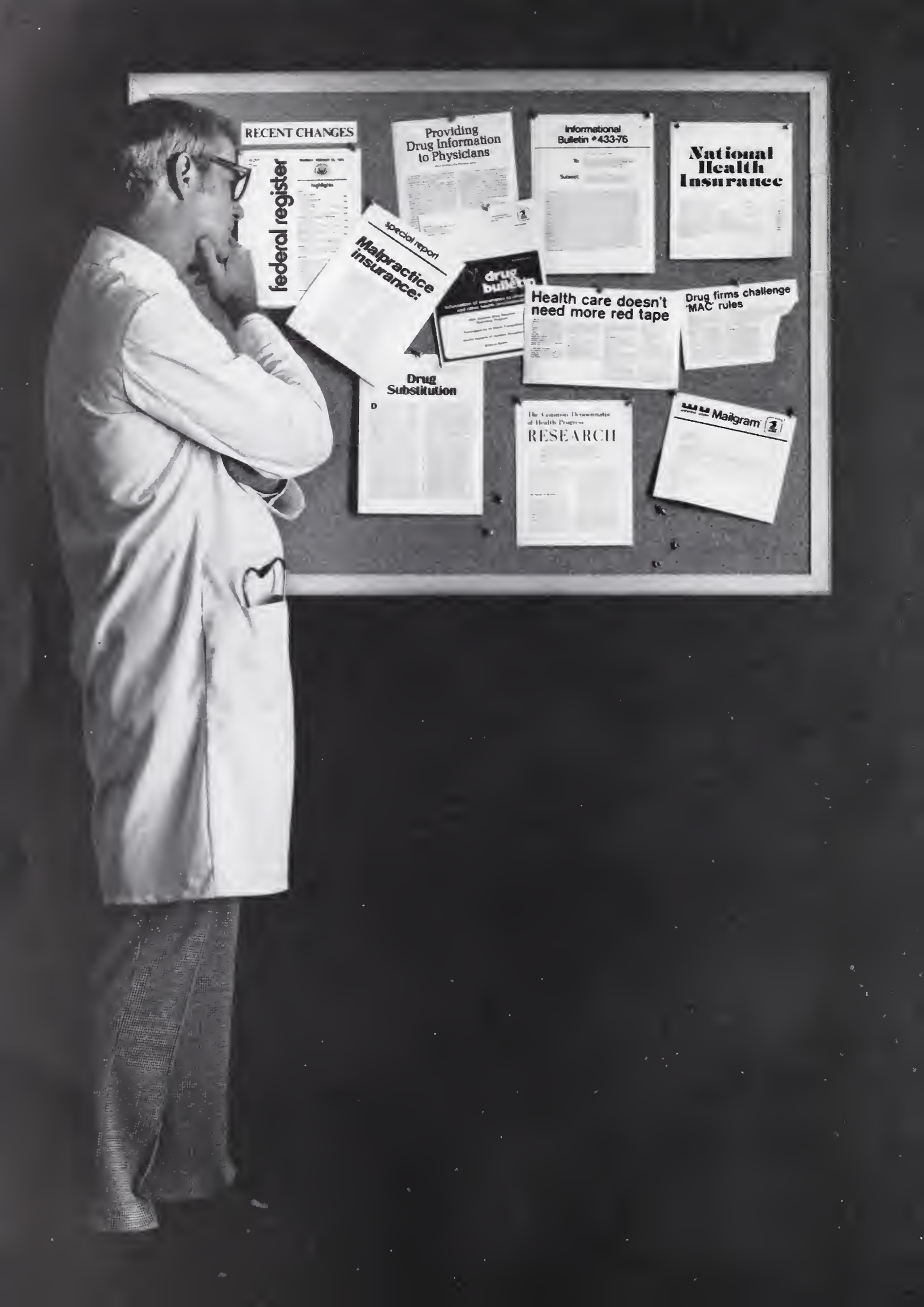
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Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

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Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

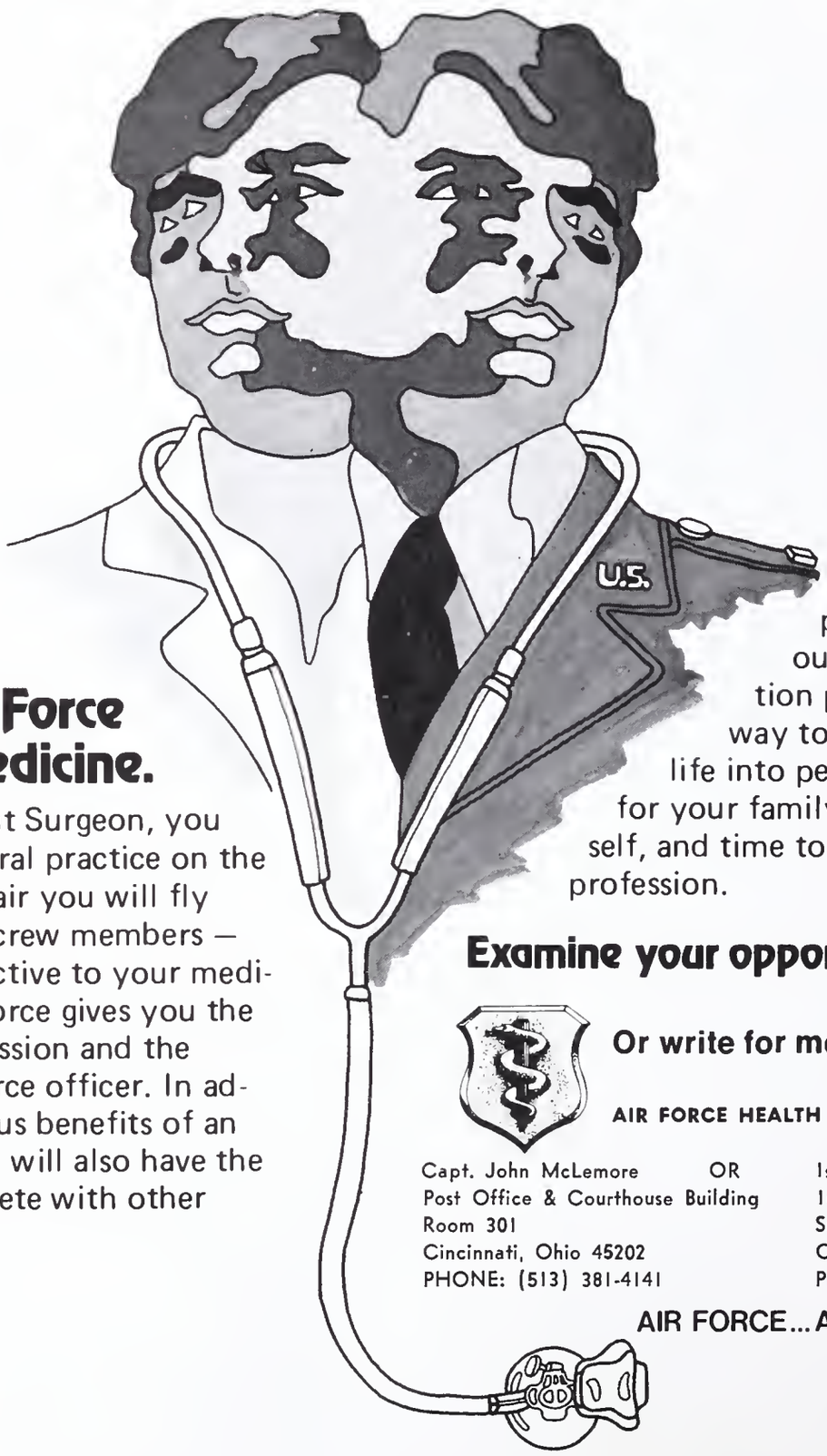
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AIR FORCE... A Great Way of Life

Long-Term Follow-Up on Patients with Fibrositis Treated with Acupuncture

George W. Waylonis, M.D.

A long-term, follow-up study of 39 patients with chronic fibrositis treated with electroacupuncture was carried out. The length of follow-up after treatment was 3 to 34 months (average 19.6 months). Forty-six precent of the patients claimed acupuncture gave the best and longest-lasting relief of symptoms of any type of treatment they had received, including partial or complete relief of symptoms. Fifty-nine percent of them felt that acupuncture was more effective than any conventional form of physical therapy. Of these 39 patients, 69 percent were taking less medication than prior to acupuncture. It is concluded that acupuncture is a useful adjunct modality in the treatment of the myofascial pain syndrome, fibrositis, and for the majority of patients, it may be more effective than ultrasound therapy, cryotherapy, and medications.

ACUPUNCTURE AS A MEANS of treatment literally burst on the American medical scene in 1971. It generated much interest by the media and the public, and all sorts of claims for amazing results were made. Patients flocked to acupuncture treatment centers in Washington, D.C., Boston, Mass., and the States of Nevada and California, where they often were treated by nonphysicians. In 1974 and 1975, physicians were bombarded by invitations to take one-week (or even weekend) courses that would teach them the "basic essentials" so that they could employ acupuncture in their practice. While all this was happening, a few university centers were attempting to determine the actual value of acupuncture to the health systems in the Western Hemisphere. Time has seen a dramatic decrease in interest on the part of the public as the promised cures failed to occur and as research teams in the U.S. failed to duplicate some of the early Chinese claims in the fields of deafness[1-3] and osteoarthritis.[4,5]

A research program to study the possible benefits of acupuncture in neuromuscular skeletal diseases was instituted at Riverside Methodist Hospital, in December 1972, by the Department of Physical Medicine of the Ohio State University. A preliminary report of our findings was made in 1973.[6] At that time, we were convinced that acupuncture was more than hypnosis and should actually be regarded as another physical modality much like other heating and electrical modalities used in physical medicine. The large number of diagnoses treated, with no single group of patients large enough to provide data for critical analysis, and a lack of long-term follow-up were two major defects in our preliminary study.

Hopefully, this report will correct these defects by focusing on one clinical entity (fibrositis, myofascial pain syndrome) in which we have been able to develop a long-term experience with a group of 39 patients.

Fibrositis, or myofascial pain syndrome, in itself, is an entity not accepted by all physicians. The term fibrositis was introduced in 1904 by Gowers, and the "nodule" concept was proposed by Stockman in 1920, according to Smythe.[7] Travell and Bigelow proposed the trigger theory of referred pain in 1946.[8] Kraft, Johnson, and LaBan emphasized the value of the "jump" sign in diagnosing the fibrositis syndrome in 1968.[9] They also placed a great deal of value on the use of ethyl chloride spray in both the diagnosis and treatment of fibrositis.

The fibrositis syndrome means many things to many people, but it may best be regarded as a syndrome characterized by painful muscles with areas of referred pain. Associated with fibrositis, one may see nonarticular pain, stiffness, and chronic fatigue. Onset of symptoms usually is early to midadulthood. The symptoms may be aggravated by physical fatigue, tension, chilling, immobilization, and occupational factors. Many of the patients may have a strong personal or family history of allergic disease. Patients with fibrositis usually are described as having completely normal laboratory examination results, including muscle biopsy and electromyographic studies.

Ibrahim, et al[10] claim lactate dehydrogenase isoenzyme patterns may be altered in fibrositis; they postulate that fibrositis is an inflammatory disease of the interstitial connective tissue of muscle. The symptoms usually have an intermittent course of remission and exacerbation; they often may be precipitated by emotional stress or weather change and have been treated traditionally with

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Submitted October 18, 1976.

analgesics, muscle relaxants, physical therapy, and injections of steroids and/or lidocaine.

Points of local tenderness occur with great frequency at predictable sites: mid-trapezius, origin of the spinati, insertion of the rhomboid into the scapula and the upper buttock. Many physicians (including the author) feel the muscles of patients with fibrositis have a ropy consistency even when asymptomatic.[9] Since the fibrositis syndrome has no confirmatory laboratory tests to substantiate the clinical diagnosis, an attempt must be made to rule out other systemic diseases before labeling the patient "fibrositis." Included in the list of diseases that may present as fibrositis are diseases which may produce referred pain syndromes such as: cervical and lumbar degenerative disc syndromes, cardiopulmonary disease, duodenal ulcer, intrinsic renal lesions, and ankylosing spondylitis. Many previous attempts have been made to evaluate the effectiveness of different "types" of treatment in fibrositis on the basis of acute response,[8-10] but there have been no attempts at long-term follow-up.

Method

Between November 1972 and June 1975, sixty-two patients with a clinical diagnosis of fibrositis received electroacupuncture treatments for the control of their symptoms. All the patients were referred by other physicians as they had failed to respond adequately to more usual treatment programs. They were treated according to the methods and protocols previously described.[6] In August 1975, the patients were reevaluated by a questionnaire mailed to each patient. (See Questionnaire.)

Results

Thirty-nine patients (62 percent) responded to the questionnaire. This is a rather good response rate considering the length of follow-up period. Three patients had moved and their forwarding addresses were unobtainable. The age range of the respondents was 16 to 68 years (mean 38.9 years) with 32 females and seven males. The group had received a mean of 7.0 acupuncture treatment (range 1 to 20) with the length of follow-up 3 to 34 months (mean 19.6 months). Results of the questionnaire were:

Types of Treatment Prior to Acupuncture.— Thirty-three respondents had been treated with pain medications, 29 with muscle relaxants, 15 with tranquilizers, four with cortisone tablets, nine with cortisone injections, and eight had other injections. In terms of physical therapy treatment, eight had received cold therapy, 30 received superficial heat, one whirlpool treatment, 19 had ultrasound, one had diathermy, and 25 with manipulation. There was an obvious pattern of multiple treatment attempts at controlling fibrositis symptoms with various types of therapy. Three patients had received ten or more different types of treatment, 15 received seven to nine types, 11 received four to six types, and seven were given one to three types. Four patients had drug therapy only, one had physical therapy only, and only two patients had no prior treatment.

Treatment Giving the Best Relief of Symptoms.— Eighteen patients (46 percent) claimed that acupuncture gave the "best" relief of symptoms of anything they had tried. Pain medications were reported as best for five patients, muscle relaxants for five, ultrasound for four, exercise, heat, massage, diathermy, cortisone, hot packs, whirlpool, and manipulation each were the choice of treatment for *one* respondent each. Three patients did not respond to this question.

Treatment Giving the Longest Relief of Symptoms.— The same 18 patients mentioned in the previous paragraph also claimed that acupuncture provided the longest relief of anything they had tried. Three patients ranked pain medications, muscle relaxants, ultrasound therapy, and heat massage as giving the longest relief of symptoms. Cortisone injections were reported best for two; exercise, whirlpool, tranquilizers, and manipulation were listed as best for one each. Again, three patients failed to respond to the question.

Least Effective Treatment in Fibrositis.— Some of the most interesting responses were found in this category. Ten of the 23 patients who had received cervical traction treatment claimed traction *aggravated* rather than helped their symptoms. Ultrasound therapy and pain medications were found least effective by six; muscle relaxants by four; massage, heat, acupuncture, exercise, cold, and tranquilizers by two each. Seven patients failed to respond to the question.

Effect of Acupuncture on Fibrositis.— Although acupuncture was regarded as the most effective form of treatment by the largest group of patients, only eight of them had complete relief of symptoms. Eighteen had partial relief (ie, 50 to 90 percent improved). Five patients claimed a borderline response (10 to 40 percent), and seven had no response whatsoever. One patient claimed the acupuncture aggravated her symptoms. Twenty-six of the respondents (67 percent) claimed a significant response to acupuncture.

Duration of Acupuncture Effect.— Twenty-two of the respondents (56 percent) had a duration of effect from 1 to over 12 months. Four patients had benefits lasting one to two months, seven lasting three to six months, five lasting seven to nine months, and six lasting ten months or longer. Ten patients (26 percent) claimed a short-lived response of several days to four weeks. Three patients claimed a benefit for one day or less and four reported no benefit at all! Acupuncture can produce a placebo effect, just like any medical or surgical modality, but most authorities agree that the placebo effect rarely lasts more than one week and never over one month.

Booster Treatments.— We pointed out in our original study that fibrositis patients frequently experience an

exacerbation or breakthrough of their symptoms following completion of acupuncture or any other program of therapy.[6] Eighteen (46 percent) of our series requested further booster acupuncture treatments. Thirteen of these reported the booster treatments were effective, while five stated they had little or no response to the subsequent treatments. The average number of booster treatments was 2.6 (range 1 to 14). This breakthrough of symptoms usually occurred 1 to 12 months after completing the initial course of treatment.

Comparison of Acupuncture and Physical Therapy.— One of the most striking observations to a physiatrist was that 23 patients (59 percent) found acupuncture more effective than any other physical therapy measure in controlling their symptoms. Only eight patients found physical therapy more effective (four votes for heat and massage, and one vote each for ultrasound, medications, massage, and whirlpool-massage). Five patients noted that neither acupuncture nor therapy was effective, and three found both were "somewhat" effective.

Adverse Side Effects from Treatment.— Twenty-six patients (66 percent) claimed no adverse effects from any of the therapies, while 13 complained of some side effects from one or more types of therapy: medications — six; acupuncture — three; traction — three; cortisone and exercise — one each; and not specified — one. Adverse reactions to acupuncture included weakness and faintness; increased pain, and "pimples on the back" in one patient each.

Medication Use Since Acupuncture.— Twenty-seven patients (64 percent) reported using "less" medication for pain relief than prior to acupuncture. Only three patients reported using more medication. (All had failed to respond to acupuncture.) Six were using the same amount of medication as before acupuncture.

Discussion and Conclusions

When acupuncture appeared on the medical scene, the early reports of 70 to 95 percent success rates were met with widespread criticism because of the lack of follow-up and/or comparison with other forms of treatment. This study presents a first-time attempt at long-term follow-up (average 19.6 months) of a single, clinical entity treated with acupuncture. It attempts to compare the quality and duration of response effectiveness to other more conventional means of therapy. On the basis of other reports from acupuncture centers around the country, it has become apparent that acupuncture "doesn't cure anything" but appears to be of value mainly in the symptomatic control of pain. It should be regarded as another modality which may be more effective for some patients than any other conventional methods (ie, drugs, injections, and physical agents) in the treatment of fibrositis. Only 46 percent of our patients claimed it was more effective than any other single method of treatment. However, the duration of acupuncture effectiveness exceeds what could be expected from a pure placebo effect

Questionnaire

1. Prior to taking acupuncture treatments for your fibrositis, which of these other forms of treatment did you use?

Pain medications	Cold
Muscle relaxants	Heat
Tranquilizers	Ultrasound
Cortisone pills	Massage
Cortisone shots	Exercise
Other injections	Traction
Physical therapy	Other

2. Which form of treatment(s) has given you the best symptomatic relief of your fibrositis? The longest symptomatic relief of your fibrositis?
3. Which form of treatment was least effective?
4. What effect did the acupuncture have on your fibrositis?
5. How long did the effects of acupuncture last (in days, weeks, or months)?
6. Did you take any booster acupuncture treatments? If so, were they effective?
7. How would you compare the effects of acupuncture and physical therapy in treating your fibrositis?
8. Did you have any other effects, or adverse side effects from any forms of treatment for your fibrositis? ___ Yes ___ No
9. Are you taking *more, same,* or *less* medication since taking the acupuncture treatments?

and exceeded all other methods in this study by a 6:1 ratio.

Fifty-nine percent of the respondents claimed acupuncture was more effective than any single or combination of physical therapy techniques while only 20 percent regarded physical therapy more effective than acupuncture. In contrast to the opinion of Kraft[9] and Bonica,[11] there appeared to be little enthusiasm for cold or ethyl chloride sprays among our patients. Twenty-three (59 percent) of the respondents had received cervical traction somewhere along the line, and ten of them found this commonly used modality aggravated their symptoms.

One way to assess the effectiveness of a treatment modality may be its impact on medication use by the patient with a chronic pain syndrome, according to Sternbach.[12] This may be especially significant in outpatients who have the opportunity to self-medicate, in contrast to inpatients whose drug use may be closely controlled by physicians and nurses. Sixty-nine percent of our patients reported using less medication (ie, analgesics, relaxants, tranquilizers) following the completion of the acupuncture program.

On the basis of these observations, we feel secure in reaffirming our earlier postulate that subcutaneous electrical stimulation (electroacupuncture) may prove to be a useful, adjunct modality for physicians dealing with neuromuscular pain syndromes and that it may partially replace ultrasound, cryotherapy, and medications in the treatment of the myofascial pain syndrome, fibrositis.

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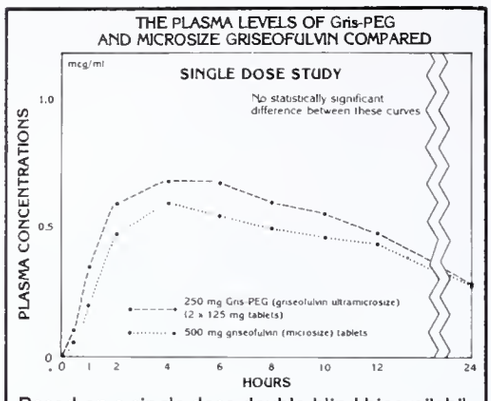
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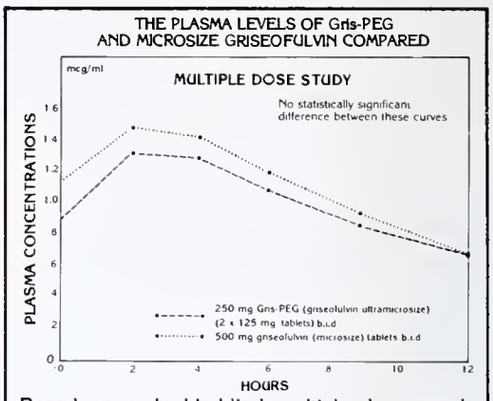
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DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum, Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks, *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Humen Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis, tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all ceses, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YB

THE OHIO STATE Medical Association Clinical and Scientific Specialty Series

Preseason Preparation— Screening and Conditioning*

Panelists: Thomas E. Shaffer, M.D., Moderator
Richard F. Slager, M.D.
Emily E. Lutz, M.D.
H. Spencer Turner, M.D.
Kenneth C. Wolfert, A.T.C.

Today's widespread interest in physical fitness, exercise, and recreational and competitive sports makes it essential that physicians have current knowledge of the medical aspects of sports.

Conferences on sports medicine have been included in the programs of medical meetings in Ohio and other states for many years. However, these meetings have reached only a small portion of the physicians involved in sports medicine.

Therefore, the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association is producing a series of panel discussions on important aspects of sports medicine to be published from time to time in The Ohio State Medical Journal. Robert D. Clinger, OSMA Director of Department of Health Education and Associate Executive Director, was responsible for the coordination of this project and its ultimate appearance in print.

It is hoped that these panel discussions will be of benefit to the physican in his continuing education — with the ultimate goal of safe athletic programs and healthy athletes. This panel discussion, first of the series, covers the key area of preseason preparation with major emphasis on screening and conditioning.

Medical Examination

Moderator Shaffer: Dr. Turner, how does a medical examination of an athlete differ from the health appraisal of any well person?

Dr. Turner: There are two basic ways of making medical examinations. One is the so-called "executive health appraisal" which is a very comprehensive examination. The more common type of examination is done with a specific reason or purpose in mind. Examinations for athletic participation usually fall into this second category. Unfortunately, we often don't distinguish one type of sport activity from another. We must recognize that there are very specific things to look for in considering a given sport. Frequently, I fear, we make a very superficial physical examination which accomplishes little more than finding out that a person can stand, is warm, and has a blood pressure which is normal.

There are specific things which should be accomplished during an athletic physical. First, we need an evaluation of the cardiovascular and respiratory systems. This should be related to the person's age and past history. I don't believe that it is necessary to make an ordinary electrocardiogram—or stress electrocardiogram—on every athlete, particularly the younger ones. Further, I don't think a routine x-ray film of the chest is necessary for every youngster. Hopefully, a chest roentgenograph is made every two or three years or so by their own physician.

We are particularly concerned about evaluation of the heart for congenital defects. I'm amazed at how often we find college students who have a congenital heart murmur of some significance that apparently had never been mentioned—and yet the person supposedly has been examined for sports activity and participated in athletics for a number of years. Certainly an evaluation of blood pressure is important, as is evaluation of peripheral pulses.

*Sports Medicine Forum held December 19, 1976 at Ohio State Medical Association Headquarters, 600 South High Street, Columbus, Ohio.

Examination of the abdomen usually reveals few abnormal conditions to concern us. However, we must keep in mind the possibility of splenic or liver enlargement, due to infections, including infectious mononucleosis, or hepatitis.

We must evaluate the genitals and check for hernias, particularly the femoral type in female athletes and inguinal hernias in male athletes. Umbilical hernias may occur in both sexes.

It's difficult to generalize about evaluation of the eyes and ears. We make sure the youngster has binocular vision with adequate acuity to meet the demands of the particular sport. The same applies to screening for hearing.

A basic neurologic examination is mandatory. We should be sure the balance is intact and that the young athlete doesn't have a history of repeated head injuries.

Particular emphasis in examination of athletes should be placed on evaluating the musculoskeletal system. The reasons are obvious—it's not simply whether the youngster can move about, but can he functionally meet the demands of the given sport in which he wants to engage. Dr. Slager, undoubtedly, will comment on this subject a little later.

The examination for participation in sports is unique in that we must consider the unusual stresses an athlete will encounter in the future. Example: A mild, patellar chondromalacia in a 50-year-old executive who is relatively sedentary is not of great significance to him in his daily activities. However, a history of chondromalacia in an 18- or 19-year-old who is planning to be an endurance runner has great significance.

Moderator: Dr. Slager would you care to comment?

Dr. Slager: Both the athlete and his family should provide an appropriate history so the physicians can direct their attention to the areas of concern.

Millions of Americans have been evaluated with properly managed, mass physical examinations for entrance into the armed forces. The success rate for finding disqualifying entities was high. So, I feel that the mass or group physical examination is suitable for medical evaluation of athletes if properly conducted.

A comprehensive, routine physical examination should apply for an entire year. This emphasizes the importance of a health history. A young athlete shouldn't require a physical examination before each sport season unless there is a specific indication from past medical history or a recent illness or injury.



Richard F. Slager, M.D.

The gross examination of the musculoskeletal system is probably the easiest portion of the overall physical examination, but it may be the most difficult from the standpoint of specific functions and defects.

First, when you look at an individual from the front, then from the side, and finally from the posterior view, you get a quick evaluation of any abnormal positions of the pelvis or shoulders. You also can detect any atrophy.

The side-view inspection of the lower back is important because several congenital abnormalities involve that region of the back. Spondylolisthesis predisposes an individual to low back complaints, especially in collision sports. There may be back pain and hamstring muscle spasms with this condition. Bending forward with the knees straight is difficult, and examination often reveals a stiff spine.

From the posterior view, you check for curvature of the spine. A hair patch at the lower portion of the spine might indicate an underlying congenital abnormality that would indicate predisposition to future problems.

A deep knee bend and duckwalk, for only a short distance, should indicate stability or weaknesses of the knees and lower extremities. You can elicit muscle weakness by having the individual sit on the floor and get to the erect position without using his upper extremities. It is difficult or impossible to do this without using the hands if there is significant weakness of the lower extremities.

Medical Examination of the Female Athlete

Moderator: Dr. Lutz, are there any special considerations in examining female athletes?

Dr. Lutz: I don't think females are particularly different in respect to physical examinations for sports activities. I agree that the health history is extremely important.

The group physical examination is not suited to examining girls unless a facility with emphasis on privacy can be provided. Today's young girls aren't quite so concerned about this as before —but they're still somewhat modest. Many schools do not have facilities to set up booths and curtains. Thus, I believe examination by the family physician is a better approach for young women.

Moderator: Girls might wear bathing suits in order to feel more comfortable for mass physicals. Could satisfactory examinations be made in this way in a school?

Lutz: I think so.

Moderator: Do you think a pelvic examination should be included in the examination of a female athlete?

Lutz: No, unless her history indicates a possible problem in that area.

Moderator: Dr. Turner, since you frequently see female athletes, do you want to say anything about their medical examinations?

Turner: I don't think of anything particularly different in the examination procedure. In considering the stresses of injuries involved in their athletic activities, females are really no different from males.

Laboratory Studies

Moderator: What type of laboratory studies should be made in preseason physicals?

Turner: We've heard arguments against doing any—and arguments for doing a lot. I believe that, as a minimum, we should have the results of a urinalysis for protein and sugar, and hemoglobin and/or hematocrit reading. With women athletes, the most common thing we find on preseason examinations, aside from the musculoskeletal abnormalities, is anemia, usually of the iron-deficiency type. This usually requires a careful history and possibly a pelvic examination because of the relationship to menorrhagia. Significant anemia requiring evaluation and treatment is the most common reason for putting a "hold" on approval of women athletes.

Slager: From what athletic endeavors would you "hold" a girl because of her anemia?

Turner: You look at the total picture. With a hemoglobin level below 10 gm/100 ml, I will not allow the girl to participate in any athletic event until the cause is determined, treatment begun, and I have seen response to therapy. With a hemoglobin level between 10 and 12 gm/100 ml, I treat her but usually let her participate in most sports, with medical follow-ups. I have no great concern about a woman athlete with a hemoglobin level above 12 gm/100 ml.

Does the Sport Affect the Health Appraisal?

Moderator: Should the athlete's health appraisal differ according to the particular sport? For example, Dr. Lutz, should the medical evaluation be different for a girl interested in tennis from that for a girl who wants to play basketball or volleyball?

Lutz: No, so far as general health is concerned. Body morphology affects their possible future success in some sports. A lot of girls, and boys too, go out for several sports at the high school level. Thus, the general, preparticipation examination should be geared both to the general aspect of overall athletic participation and to consideration of individual sports.

Mr. Wolfert: One of the factors we must think about in the appraisal of school-age athletes is their *physiologic maturity*. For example, a youngster competing with someone of the same age may not be as far advanced in physiologic maturity as the other youngster.

We need to identify the immature ones by paying attention to physical and sexual development and to steer them to an athletic endeavor in which they can compete at their present stage of development. Our obligation even extends beyond guiding youngsters into certain sports or away from others. By all means, we should avoid having them feel rejected when unlimited approval cannot be given.

Provide an alternative. For example, an aspiring football player presently lacking in the physiologic maturity of his peer group could be encouraged to play baseball or tennis, at least on a temporary basis. Athletic trainers can play an important part in this, because they have more time for it than does the physician.

Slager: Ken has made a very important point. There is some physical activity suitable for each individual. A person who has otitis externa should not be encouraged to be a swimmer. A youngster who has frequent coryza or problems with dust in his eyes shouldn't be encouraged to be running long distances on a track in a dusty gym. A youngster with a hernia, if he elects not to have an operation, shouldn't be approved for wrestling or allowed to do weight training. There are always alternatives. If the youngster with the hernia would like to be a swimmer, I see much less risk in that than in wrestling. A youngster with a history of several cerebral concussions shouldn't be permitted to participate in sports where there is severe body contact. Baseball might be an excellent alternative for him. A youngster with a history of cardiac problems should not engage in such endurance activities as basketball, soccer, football, distance running, and swimming. Variations in physical maturity make a tremendous difference in ability of individuals to achieve. Many youths have been "turned off" because they can't keep up with others of their age level. To help prevent this, the physician should become a "counselor" and advise the slowly maturing youngsters to take up an alternative sport where size and strength are not markedly important.

Turner: Athletic medicine is, in many respects, a unique type of occupational medicine. Many years ago, we stopped making pre-employment examinations in occupational medicine and initiated *preplacement* examinations. If, as Ken Wolfert has suggested, this concept is carried through to the preseason physical for sports, we would help the youngster to be placed in an activity appropriate for him at his stage of development.

Lutz: We seem to be concentrating on participation in varsity sports. A lot of youngsters will participate only in intramurals. Many of these have never had a thorough medical examination, especially one for an athletic team. You might reject a student for varsity basketball, who then could play intramural basketball without medical approval. Medical examinations usually are limited to candidates for interscholastic sports but we really should have the same concerns for all athletes in a school.

Help the Athlete Select an Appropriate Sport

Moderator: We made a point that, in addition to examining a would-be athlete, the physician should counsel some of them about selecting an appropriate sport.

Turner: Just as it makes no sense for a family physician to tell a mother of four young children to spend a few days at complete bedrest, you can't

arbitrarily qualify or disqualify an individual from *all* sports. It may be important to a high-salaried, professional athlete to risk the possibility of needing a complete arthroplasty ten years down the road, but that may not be the way for the 15-year-old whom we can direct to a more appropriate type of activity.

Slager: We have given our approval to group or mass physical examinations, but it should be emphasized that each youngster later could sit down alone with the physician, who might say: "You are perfectly normal and you can play any sport you wish," or he might say: "Maybe you should consider an activity other than basketball or football due to your own personal physical limitations."

The Group Examination

Moderator: In mass or group examinations, is it better to have stations where each physician examines a particular portion of the anatomy, one listening to heart and lungs, another checking the musculoskeletal system, and so on, or is it better to have one physician make an entire examination?

Slager: Although ideal to have one physician to one individual, I would be satisfied with either plan as long as the examination is thorough.

Lutz: I'm not against mass physical examinations, but the family physician can do certain things better. Not only can he interpret the examination, but he knows the family; as a rule, he's seen the youngster grow, and he should have a better perspective as to the ultimate physical development of the boy or girl than would a physician who doesn't know the youngster.

Moderator: Do you recommend that a young athlete's personal physician should make the examination?

Lutz: Yes, although I agree that hasty examinations are made at times. Compared to a very cursory one by a busy practitioner who doesn't give a comprehensive examination, it would be better to have a group examined cooperatively by physicians specifically aiming to meet the requirements of a good sports medical examination.

Moderator: An advantage of a group examination where several physicians of a community go to a school and examine everybody is that everyone comes to one place. All have the same kind of examination. The mass-type examination provides the same level of quality for all.

Slager: It has to be said that sometimes the personal or family physician asks, "Has anything happened since the last time I saw you?" Usually the youngster says, "No, I've been fine," and the authorization card may be filled out without an actual physical examination.

Moderator: It is likely that it doesn't make any difference which licensed physician makes the examination provided a good medical history is available and the physical examination is thorough.

Who Decides Whether a Student Should Play?

Wolfert: Who should make the final decision about playing if there is a restriction? The family physician often is not close to the athletic scene.

Moderator: What is your opinion about the final decision?

Wolfert: A consultation between the family physician and team physician or school physician is necessary. I don't think the family physician alone should have the final decision.

Moderator: Dr. Lutz, who should make the final decision about whether a person should or should not play?

Lutz: If there is an authorized team physician or school physician, I think he should. The team or school physician and the family physician should consult together when the decision is controversial.

Moderator: At the high school level, if the family physician says, "I don't want this youngster to play because he has a heart murmur," and you are the team physician, Dr. Turner, what are your options?

Turner: I believe you must say, in deference to the knowledge of the family physician: "If your family physician says you cannot play, you cannot play." That may come about after conferring with the family physician. Otherwise, the team physician *must* have the final say because it is his responsibility to deal with that youngster.

Physician Volunteers

Moderator: The trend seems to be toward having a group of physicians working as a team to examine athletes. Volunteers could help with some screening. Dr. Lutz, does this happen in your community?

Lutz: Yes, we have always had volunteers.

Moderator: Do you include some who are not physicians?

Lutz: Our volunteers include nurses and laboratory technicians as well as physicians.

Turner: In many of our communities, we can get the best of two worlds. That means bringing together with the team's physician, the practicing physicians, nurses, and athletic trainers who live in the community. This would warrant doing examinations at one place at one time.

Wolfert: Unfortunately there are apparently many communities in Ohio that do not have that kind of cooperation. On the other hand, a high school in Cincinnati has about 20 physicians, including ophthalmologists and cardiovascular surgeons, who are eager to help. These physicians take care of injuries during the season, as well as giving the preparticipation physicals.

However, some schools competing in the state football play-offs did not have a physician to accompany the team to the play-off games. If these schools, which had attracted consider-

able interest in their communities, did not have medical services, what do you suppose happens in those schools which do not have public acclaim?

Turner: The school officials should ask physicians in the community for help. Many physicians are eager to help *if they are asked by the coaches or school administrators.*

Visual Acuity Tests

Moderator: As a new subject, how important are tests for visual acuity of athletes.

Slager: A person who has absent or impaired vision in one or both eyes should be informed about the handicap and hazards caused by the condition. In my opinion, contact sports should be ruled out or protective glasses should be worn.

Moderator: How about testing for color perception?

Turner: We agree that both eyes should be functional, particularly for collision sports. I don't think color vision is essential, provided one can tell one color jersey from another.

Hearing Tests

Moderator: How about a hearing test in the physical examinations of athletes? The Ohio High School Athletic Association physical examination form has a section for recording hearing acuity. The physician, thus, is officially required to do a test. Consider two questions. First, is it necessary to have a hearing test and, second, how do you interpret abnormalities?

Lutz: You need to evaluate whether or not the individual hears. If there is a loss, you need further evaluation as to the extent of his participation.

Wolfert: Most elementary-age children are screened at school for hearing defects. Those with obvious hearing deficiencies already would be known and treatment or therapy already begun before the pupil reaches high school.

Slager: Can you think of any athletic event in which an individual wouldn't be allowed to play if he were deaf?



Thomas E. Shaffer, M.D.

Wolfert: The U.S. Committee on Deaf Athletes will enter world game competition this summer in Europe. About 145 females and males who cannot hear, and many of whom have no speech, will compete in basketball, wrestling, track, and field. They are in international competition.

Moderator: If you already know a person has a hearing defect, you would not need to test him or her. However, in some localities, the physical examination for sports is the *only examination* that the boy or girl gets. In that case, you would have to ascertain whether or not the sense of hearing is important in a given sport. Obviously, a deaf person can be an athlete in some sports.

Do you recommend urinalysis as part of the routine physical examination of athletes?

Turner: A screening test for protein and glucose is so simple and inexpensive that it doesn't make sense not to do it considering the amount of pathology which could be indicated by a test that takes ten seconds.

Moderator: What would you do if proteinuria were found when you examined an athlete?

Turner: You follow up to determine the cause. The youngster is removed from the routine screening at that point for more extensive evaluation.

Frequency of the Physical Examination

Moderator: What is our recommendation regarding frequency of physical examinations for athletes? In some places, a physical examination is required prior to each seasonal sport, so some are examined two or three times a year even though athletes are typically the healthiest group in the school. Dr. Lutz, how often should these routine examinations be required?

Lutz: I believe that once a year is reasonable for adolescents who are changing rather rapidly in growth and development. For example, if one is examined routinely in the fall, this should carry over through the spring unless an illness occurred that would require evaluations.

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Dr. Lutz, Circleville, Active Staff, Berger Hospital, Circleville; Courtesy Staff, The Ohio State University Hospitals; Assistant Clinical Professor, Department of Obstetrics and Gynecology, The Ohio State University College of Medicine; and Member, Joint Advisory Committee on Sports Medicine of the Ohio High School Athletic Association and the Ohio State Medical Association.

Dr. Turner, Columbus, Director, University Health Center; Team Physician, The Ohio State University; and Member, Joint Advisory Committee on Sports Medicine of the Ohio High School Athletic Association and the Ohio State Medical Association.

Mr. Wolfert, Oxford, Head Athletic Trainer, Miami University; and Member, Joint Advisory Committee on Sports Medicine of the Ohio High School Athletic Association and the Ohio State Medical Association.

Moderator: You would recommend that everyone engaged in sports be examined by a physician once a year. Any comments on that?

Wolfert: Should the preparticipation medical examination be scheduled just before practice starts—or should it be a couple of months beforehand—so that the problems can be identified and remedial work begun? Maybe the physical examination should be made in May or June before vacation. An update by interval history could be done in the fall.

Moderator: A good point, Ken. You suggest that the time of the physical examination should be relative to the possible need for time for medical treatment or rehabilitation.

Turner: It really doesn't make much difference when an examination is made if there is continuing medical care and daily review. It would be totally absurd to have an examination every day before every game or practice, but those who need medical care should receive it whenever necessary.

But, at some point during the year you should have a general, thorough evaluation. If you have continuing care on a daily basis, then you are updating the physical examination every time there is an illness, injury, or incident of any kind—and correcting it as you go along.

In many of our high schools and colleges where there is no daily observation of athletes' health, guidelines for a preparticipation physical not only should deal with the examination but also should advise continuous attention to changes in health status from intercurrent illness or injury.

Wolfert: Male and female intercollegiate sports at our university involve 600 or 700 athletes. Add to these another 500 in intramural and club sports and you will see that we have a real problem in providing medical care for all these athletes.

Some schools begin with an initial, very thorough, physical examination including a complete history and specialists' consultations. Following this, the trainer can be on the look out for problems, but as an athletic trainer, I really don't like to decide in the day-to-day course of events that one person is OK while another person should see the physician, even though that is necessary.



Kenneth C. Wolfert, A.T.C.

Moderator: That's really not so risky. Parents have to make decisions as to whether or not their child needs to see a physician, so it seems to me that a person with the special training of an athletic trainer could make that decision too. A trainer or coach may know more about health than the young mother who must decide when her baby is sick.

Turner: This points out the need for a certified athletic trainer in every high school. With a trainer, you can have the day-by-day surveillance we have talked about. It need not be a full-time job. The athletic trainer may teach part-time.

Moderator: The basis of successful school health programs has been teacher observation, with infrequent routine medical examinations but ready access to the nurse and school physician when teachers ask for it. Perhaps the point we should emphasize is that day-by-day observation is more important than frequency of examinations.

Where Should Schools Keep Medical Records?

Now, let's discuss where medical information about athletes should be kept in the school.

Lutz: That depends somewhat on the size of the school. If the athletic department has facilities for storing information, the records could be kept there although the principal is responsible for them. In our local school system, they are kept in the principal's office. The coaches and physicians have access to them.

Moderator: Should the school health records be available to the person who is responsible for the health of athletes? A member of our Joint Advisory Committee on Sports Medicine has urged that such records be available to team physicians. He says a lot of information never gets out of the school nurse's office.

Wolfert: It would help if such records were available to the physician making examinations, and the team physician should have easy access to the records.

Moderator: I know of an instance when the principal had simply counted authorization cards to be sure that all athletes had one in file. One boy's card was not signed by his physician who had made a note that the youngster should not participate because of a heart murmur. The coach first saw the card after the boy had practiced for three weeks.

Slager: The coach has to decide whether the individual is physically qualified to participate. Therefore, he should have complete access to the records.

Knee Injury

Moderator: Dr. Slager, what special advice would you have for the physician who must examine a youngster who has a history of a significant knee injury? To what degree should he be checked before he is cleared? Should he be referred to an orthopedist right away?

Slager: If an individual has had any previous surgery for management of a musculoskeletal problem, an intra-abdominal problem, or an intrathoracic problem, the team physician

should consult with the other physician concerning the problem if he questions the individual's status to participate in sports.

Moderator: Please comment on Osgood-Schlatter disease.

Slager: I had the problem as a teenager, and was taken from athletic competition for a year! There is, of course, the problem of local discomfort but there is little reason for concern about permanent disability even if the individual continues to compete. I would suggest that one protect the area with padding to reduce discomfort, but allow continued participation.

Avoid activities that cause rapid extensor movement at the knee. Osgood-Schlatter disease is a condition involving an apophyseal osteochondritis or sometimes an avulsion of the tibial tubercle. It makes sense that this individual shouldn't be a punter, and he also shouldn't jump repetitively as these would cause a maximum contraction of the quadriceps mechanism and pull at the apophysis.

A broad jumper should be restricted until asymptomatic. Other than in such activities, I see no reason for restriction.

Scoliosis

Moderator: Do you have any general advice for a girl athlete who has scoliosis?

Slager: Physical activity or exercise seems to have no effect on correcting the curvature although it was believed for many years that exercises would correct or arrest it. I encourage the girls to do all the swimming and gymnastics they would like to do, even if in a brace. I don't encourage collision sports.

Moderator: How about adolescents' kyphosis?

Slager: Scheurermann's disease is a structural entity and any longitudinal force would likely enhance progression of that entity. The weightbearing line is just anterior to the vertebral bodies, so blocking, tackling, or overhead weightlifting will enhance the deformity and, therefore, are contraindicated.

Epilepsy

Moderator: The general rule about epilepsy is that if seizures are under control by treatment, an individual should be given a chance to participate in sports. Should swimming and perhaps gymnastics be off-limits to those who have a history of seizures?

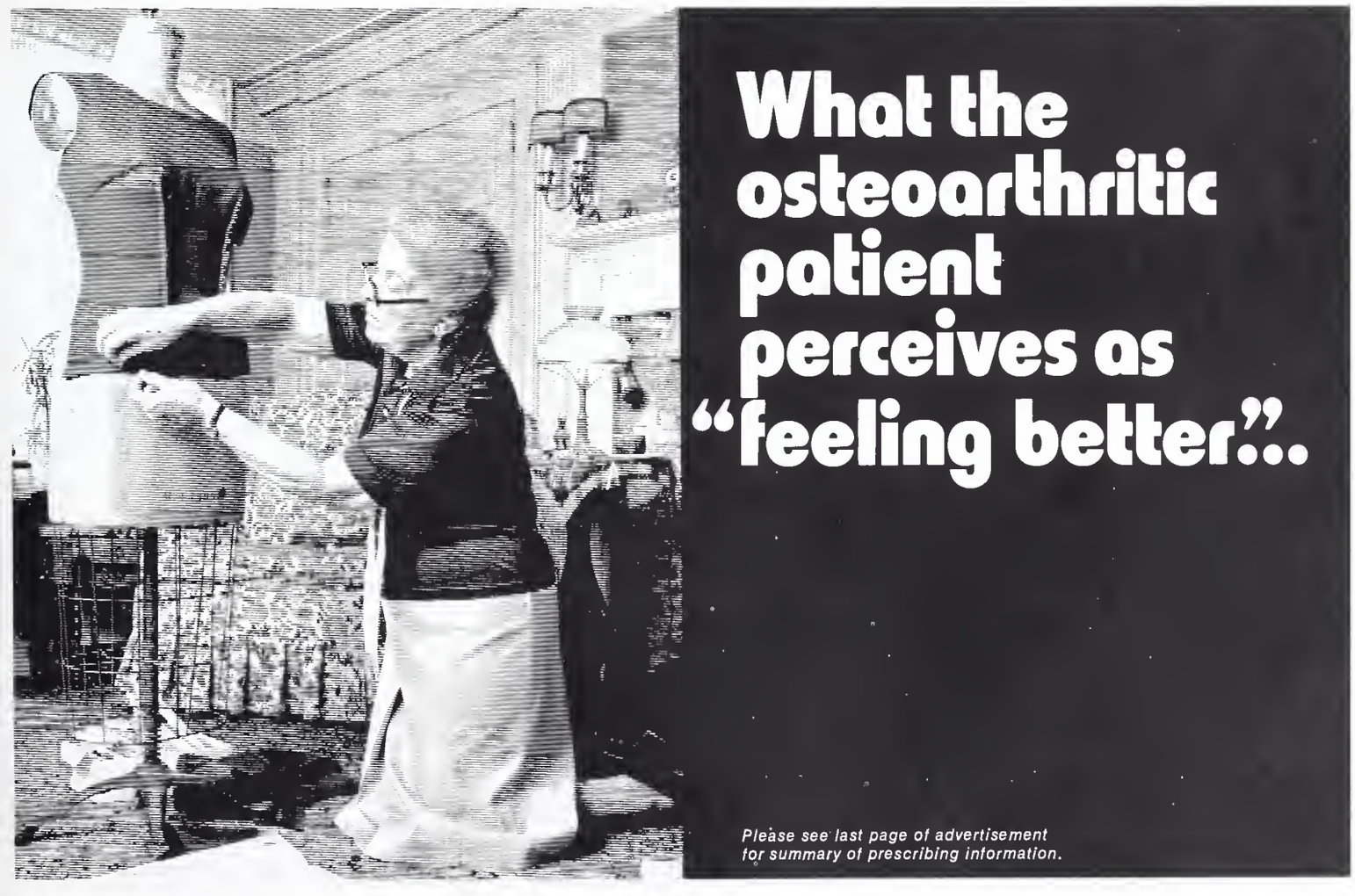
Turner: In general, I would agree.

Concussions

Moderator: What about the individual who has had previous concussions?

Slager: If an athlete has three episodes of concussion within a season, the accepted rule is that he should be required to drop out for the rest of the season.

Moderator: Why are three episodes



of concussion considered the magic number?

Slager: Having more than one concussion suggests possibility of predisposition. After an individual has had three episodes in which he is unable to respond to questions regarding time and place, I would not take the responsibility, as a team physician, to let him continue to play.

Turner: In general, three is a reasonable number, if one takes into consideration the severity and duration of the symptoms. In some situations, two concussions would be the limit, as in the case of the individual with a long period of disorientation.

Most concussions are minor ones—involving a transient period of disorientation with complete recovery within 30 to 60 seconds. This is the type of concussion we refer to in saying "three strikes and you're out."

Moderator: Ken, do you have a general rule at Miami University about concussion?

Wolfert: No firm rule. We depend upon consultation with the neurosurgeon or neurologist—especially in cases of moderate and severe concussions. When an athlete gets the first moderate or severe concussion, we give him a week to two weeks to recover. If he has a second concussion, we rule him out for the rest of that season. In the following year, after one more concussion, we urge giving up contact sports.

Asthma

Moderator: Dr. Lutz, do you put any restrictions on the athlete who has asthma?

Lutz: If they are not symptomatic and participation doesn't worsen their condition, I see no reason to restrict them.

Conditioning Program

Moderator: Let's move to a new subject. Ken, how would you describe a good conditioning program?

Wolfert: The year-round programs will include preseason, in-season, and off-season activities that will be different in the objectives sought.

The off-season is a period of time from the end of final competition in the regular season until two weeks before the start of the next season. During this period of time, stress must be placed on *development*. Areas emphasized are muscular *strength* some *motor ability, flexibility,* and *injury rehabilitation* and correction or improvement of *physical deficiencies.*

The preseason period actually involves the last portion of the off-season because it is about six to eight weeks prior to the beginning of the official date a team can begin actual workouts. In the preseason, emphasis is on *refinement* of the conditioning objectives begun earlier in the preseason period. *Strength improvement* and *flexibility* are still important but now the *cardiovascular endurance* and *aerobic abilities* of the athlete are emphasized. In addition, proper *diet* and *weight control* is sought.

The in-season period of conditioning concerns itself mainly with *maintenance* of fitness. Here *strength* maintenance with regular weight training is imperative as is some type of aerobic type of work to keep the *endurance* levels up. Physical performance capacity is brought to competitive peak, and playing skills and game strategies are refined.

Moderator: The season ends in March for a high school basketball player. What are your instructions at the end of the season? What should he or she do during the next 12 months, including the next season of play?

Wolfert: Most young athletes are "burned out" by the time their season ends, so they need to have some time away from the activity. The length of time varies with the individual and his level of intensity. Some rest for a week and, right away, they want to start conditioning, but I believe there should not be a formalized program for the first two or three weeks after the end of the season. A definite program should be prescribed before summer vacation, with variations according to individual needs. For example, one youngster may want to increase his jumping ability, so some weight-training activities to strengthen the legs and develop the upper body should be provided.

Moderator: Would you advise working at least three times a week under supervision during the summer with weights or with special apparatus, like the Nautilus™ or Universal Gym.™

Wolfert: I like to let the athlete get into various activities whether it be baseball, volleyball, or some other sport, and not have conditioning restricted to one particular activity.

Some kids can become mentally stale by the time the season begins. When you have a winning team, everyone is caught up with success and there's a lot of "hoopla." Some coaches drive their young athletes like high-powered professionals—to the point the athletes wonder whether it's all worthwhile. However, there's more opportunity for variety in high school sports. College athletes have a great deal more pressure for specialization in a single sport.

Slager: A world-renowned distance runner decided that limiting his practice to long-distance running was no fun. He incorporated sprints into his schedule and alternated between long-distance workouts and sprints. In this, he lengthened and strengthened many different muscles, he didn't get bored, and he remained at a peak in his long-distance running events for many years. It is important that a workout have diversity.

Moderator: What should an athlete do during that six- or eight-week period that you label "preseason?"

Wolfert: That's where you step up the pace. The athlete has been working on his own two or three times a week. At the end of six weeks' intensive training, he is going five times a week in preparation for daily practice. As I said before, you want to build up endurance and strength and develop flexibility during this period.

Moderator: What advice would you give to physicians who will be asked about conditioning?

Turner: There are three aspects of conditioning, all of which are important. First is *general physical conditioning* for the average athlete who has time to work out daily both during and between seasons; second is *conditioning for specific skills for a particular sport*. This can become repetitious and tiring, thus, one must be careful in this area. Related, then, is *mental conditioning*.

As has been mentioned, an athlete may work on one set of skills until he becomes mentally fatigued. A good training program should be varied to avoid this problem.

Moderator: Dr. Slager, have you some specific recommendations about conditioning for an athlete with an unusual physical condition? For example, the young athlete who is tall, thin, and has a long neck. One might consider ruling him out of football because of his build. Would you make recommendations to enable him to play?

Slager: There is no question that those with a long, slender neck are especially susceptible to injury.* Youngsters who are immature, with underdeveloped muscles, will not succeed at the same level as their more mature classmates. However, we should encourage competition with those of similar level of maturity.

Moderator: It appears that in some high school sports more time is put into teaching skills than in conditioning. At the college level, there is more emphasis on conditioning. As a generalization, could we say that there needs to be more attention given to conditioning in high school sports?

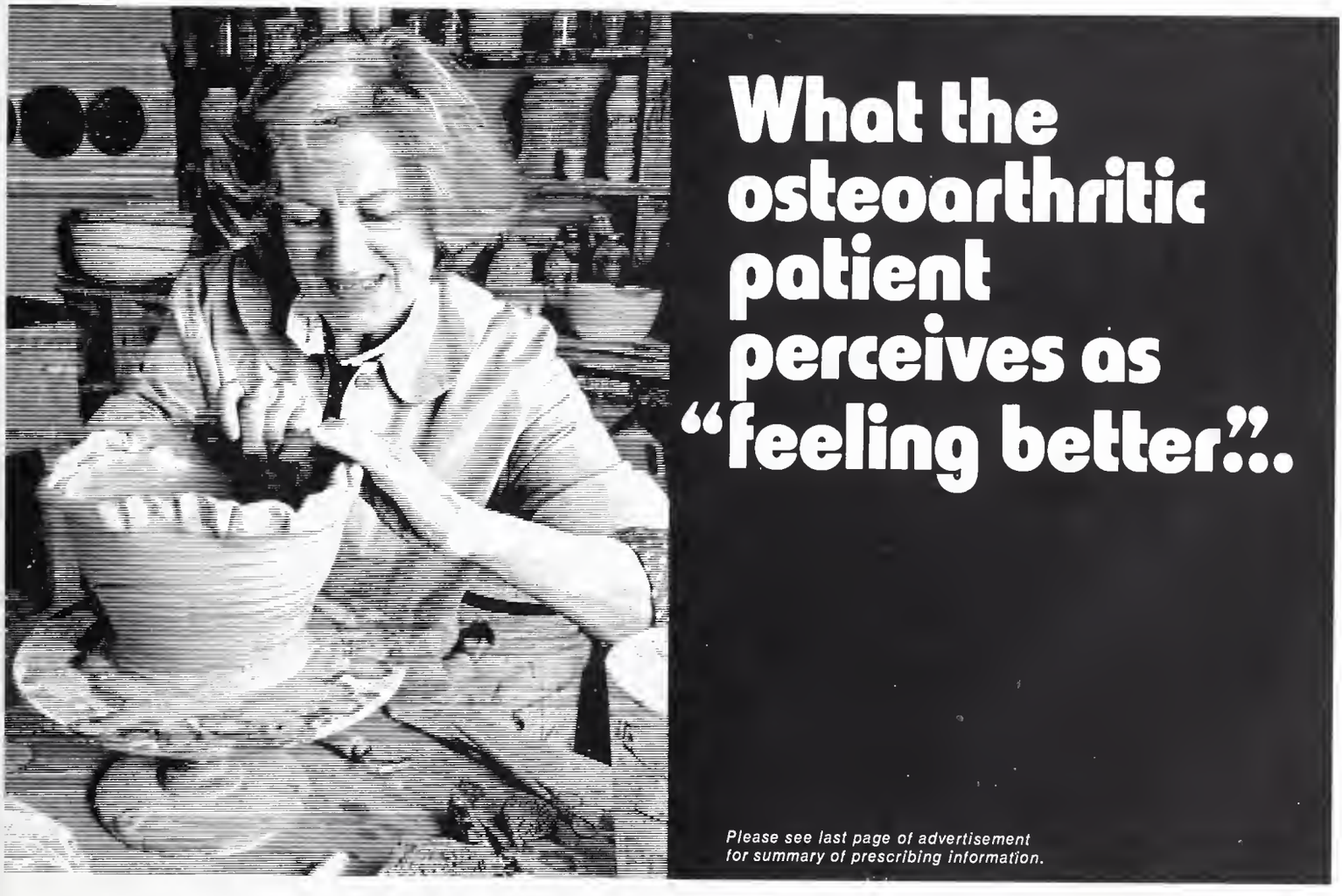
Lutz: I think you could make such a statement about girls' athletics. Conditioning is practically nonexistent in many instances. Also, there is the problem of availability of facilities for the girls. It is hard for them to utilize machines which the boys' teams are using. Continuing conditioning throughout the year is largely nonexistent in girls' programs.

*Specific information about muscle-strengthening exercises may be obtained by writing to OSMA.

Principles of Physiological Chemistry Which Apply to Conditioning

Turner: Perhaps we should review a few principles of physiological chemistry which apply to physical conditioning. The immediate source of energy for all activities is adenosine triphosphate (ATP), the energy reserve of muscles. ATP is supplied to the muscles in three ways. Two are so-caller *anaerobic* (without oxygen) mechanisms, the third is the *aerobic* (with oxygen) method.

One anaerobic system is called ATP-PC, PC (phosphocreatine) being the source of ATP energy. The ATP-PC system, located within the muscle cells, is instantly available for short, high-



power needs for energy as in an activity of less than ten seconds' duration. Examples would include the 100-yard dash, pitching, high-jumping, or shotputting.

A second mechanism, also anaerobic, comes into play for high-intensity efforts lasting up to three minutes, for example the 400-yard dash. ATP having been "used up" in a few seconds, glucose is chemically and anaerobically converted to lactic acid, which allows ATP to be manufactured and made available to the muscles. A rising level of lactic acid in the blood and, thus, fatigue occurs when insufficient oxygen is present for constant production of energy from foods. In this system, accumulation of lactic acid soon occurs, resulting in symptoms of fatigue.

The third energy mechanism, the aerobic or oxygen system, produces energy (ATP) from carbohydrates and fats in the presence of oxygen. This process can continue as long as oxygen is available in the muscles. It is the mechanism which produces ATP for endurance events like cross-country, soccer, marathon events, and modern basketball.

When you consider these three systems of energy production in relation to the requirements of a particular sport in question, training procedures can be planned to maximize an individual's capability for using the energy source he or she is most likely to need in performing a given sport.

Without going into further detail, an excellent reference is the book by Doctors Fox and Mathews entitled *Interval Training,* which gives instructions about how one can best develop each of those three systems to meet the requirements of various sports.

Moderator: Dr. Turner has referred to "intensive interval training." The word is out that it is one of the best ways to get in condition, perhaps superior to continuous running. Just what is it?

Turner: "Interval training" simply means using training techniques which develop abilities to utilize all three systems. The meaning of "interval" in the phrase is that introducing a brief recess or relief interval in exertion during training permits some recovery or replenishment of energy. The process can be enhanced by repeated exhaustion of energy followed by relief intervals.

Moderator: Can you increase anaerobic capacity as well as aerobic capacity by conditioning procedures?

Turner: Yes, or at least you can increase your capacity to properly use those systems.

Wolfert: Results from interval training indicate a major breakthrough in sports. Improved performances occur year after year. These may or may not be a result of interval training alone, but I think it has been a major factor. In track and field, swimming, wrestling, and football, interval training maintains in-season cardiovascular efficiency. I, too, advise reference to *Interval Training* by Fox and Mathews.

Isometric and Isokinetic Activities

Moderator: We should turn now to consideration of the effectiveness of isometric and isokinetic activities.

Slager: There has been some concern that an exercise program, particularly one using weights, produces hypertrophy of muscles which tend to make an individual muscle-bound with diminished flexibility and less ability to perform some necessary precision activities.

However, many individuals lack the abilities to perform specialized skills; when it is found that they can't throw or kick, despite big muscles developed in conditioning, these athletes are considered to be "muscle bound."

Strength-producing exercises should be prescribed to suit the specific aspirations of the athlete. For maximum effectiveness, a football lineman should have a large amount of muscle mass, which could be developed by isometric exercises. The punter, passer, running back or receiver, and the runner on the track team, wants to develop muscles through a wide range of motion and should utilize isokinetic activities. Flexibility, as well as increase in strength, are equally important. Weight machines which encourage full range of motion are the best, and the Nautilus machine does this. If an individual wishes to develop strength and muscle mass only, either isometric or isokinetic exercises will serve the purpose.

Moderator: Is weight training, which I understand to be isokinetic or isotonic activity, depending on whether or not one uses a machine to provide resistance, a desirable part of conditioning for athletes in all sports?

Slager: Weight training should be included because everyone likes to have some indication as to whether there is improvement. Self-evaluation is helpful and very positive.

Wolfert: We are coming from the dark ages as far as weight training goes, and there still is more to learn. I'm convinced there are two reasons for weight training. One is to *improve performance.* The other is the *prevention of injury.* The coach wants to see both of these occur. The trainer aims to eliminate injuries, and, if performance is improved as a result of fewer injuries, that's fine.

I think weight training can be used for both boys and girls in all sports. Even a super athlete with lots of natural ability and strength, who has never engaged in weight training, can benefit from a correct program.

People with bulky muscles, tight joints, and some loss of range of motion have been allowed to use weights incorrectly. The procedure could have been more like *weight lifting,* which is a competitive sport event. This is the wrong technique for the conditioning process we call *weight training.*

When one lifts a weight, he is weakest at the starting point, gets stronger and stronger with contraction of the muscle group as if on a bell curve, and becomes weaker at the other end. If one lifts only 20 pounds, he's not accomplishing anything at the muscle's strongest point. Some will try 100 pounds to test the maximum strength. It is too heavy at the starting point but can be managed at the midposition so they cheat by throwing

it or rocking it, to get it up within the range of greatest strength; this puts strain and stress on the joints. They increase strength in a narrow range, but they also strain muscles and tendons and lose flexibility.

The Nautilus strength-training concept has an advantage in that the person is strapped in a position where only a certain muscle group can be used. This forces full range of motion as well as prestretching which activates more muscle fibers to respond.

Research is showing that we have neglected negative-type exercise in development of strength. "Lifting down" the weight is negative, and lifting up is positive. What you lift back down is also work. We have neglected that reverse action in what is called isokinetics. In isokinetics, you are getting only the positive aspect.

Coaches strive for explosiveness. They want to develop fast, quick movements and weight training usually has done that, particularly for the extremities.

Strength is developed by an overload. You have to stress muscle beyond its usual range, by going to the point where it is impossible to accomplish any more. This point of failure is not harmful. If, after fatiguing muscles repeatedly six or seven times, you then want to "explode" with maximum effort, you are so tired that there is no way you are going to harm that muscle or tear it. The only way one can tear muscle fibers is by jerking the weight, which is the incorrect way.

So, we must stress the values of intensity of effort (in which one works hard until he can do no more), and then you come back to the original position. There is an inclination to stop short of complete fatigue. Present conditioning methods utilize many of these new principles. One can do the whole thing by using the bar bell. A Nautilus machine is not necessary. Athletes must be instructed properly, have supervision, and be willing to break old habits, which is the hardest part. They don't feel like they are getting anywhere; they need someone to instruct and encourage them.

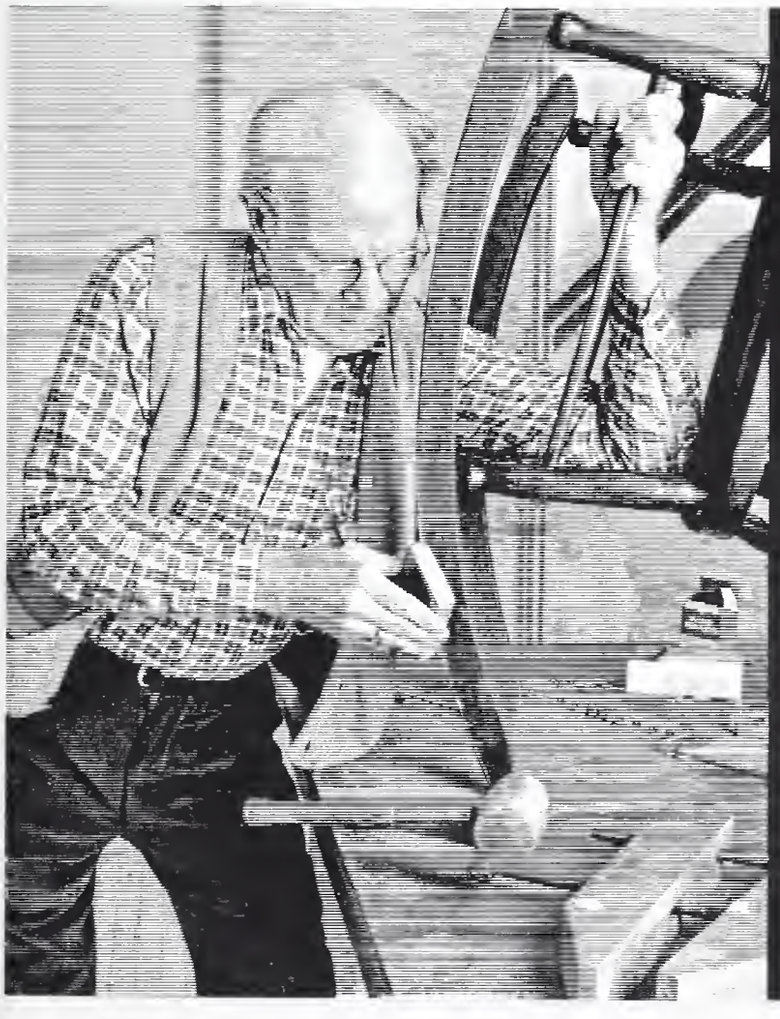
Another thing to consider is that strength training and weight training have nothing to do with skill. Skill must be taught in practice. You will not necessarily throw a baseball farther because you have become stronger in your shoulders. If you don't throw, you can lift weights all you want, but you will not be able to throw the ball any farther.

Moderator: What do you think about girls going into strength development programs? Is it feasible to have the same program for females?

Lutz: Certainly. Same as for the boys.

Turner: No question about that. There is no physiological reason why they shouldn't have the same training techniques and routines as the male athletes. Women athletes at Ohio State University work on the Nautilus and Universal Gym. Once you overcome their concern that they will develop huge muscles like the weightlifters, the women are enthusiastic about this effective training procedure.

Slager: As soon as a particular portion of the training program is shown



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to cause an individual to perform at a higher level, others are going to try it regardless of whether a boy or girl did it first.

Lutz: Has anyone, under equal conditions of adequate training and preparation, found any differences in the types of injuries suffered by female athletes?

Turner: Dr. Shaffer and I did research on this. We found no difference, nor have others who have studied the subject.

The Warm-up

Moderator: How important is a warm-up before practice or game?

Slager: All muscles and ligamentous structures have elastic fibers within them which seem to be more elastic at an increased body temperature than when they are cold. The tensile strength of muscle is influenced by having the elastic fibers work at their maximum.

Thus, anything you can do to stretch and lengthen the muscle fibers and the elastic fibers prior to bursts of activity will decrease the chances of having torn muscles, tendons, and ligaments.

There comes a time, however, when you overdo the warm-up and cause the muscles to fatigue. But, short of this, the warm-up is extremely important.

Moderator: The warm-up is a requirement for scholastic teams in some sports before the game and after the halftime interval.

Slager: The Joint Advisory Committee on Sports Medicine supported the decision of the Ohio High School Athletic Association to lengthen the half-time intermission of football games to allow for a five-minute warm-up prior to the second half of play.

Moderator: Are there any special recommendations about warm-up or is it generally accepted that it should routinely be calisthenics, running, and some stretching exercises?

Wolfert: The trend is toward spending about ten minutes initially on a static program of stretching various groups of muscles simply to the extent of comfortable range of motion and holding that position for three to five seconds. This sort of initial warm-up has been popular with ballet dancers and gymnasts for years. Day by day, the range of motion will increase. Forcible stretching, as in bounce exercises and the "hurdler's stretch," are out.

After going through the isometric-type flexibility movements, we would spend another ten minutes in agility-reaction drills which are more dynamic. So you need about 20 minutes to warm up properly before full-go in a practice or game. A person must be in good physical condition to go through that kind of warm-up.*

Most of us have seen a sprinter develop a hamstring muscle problem which ended his career. That's because sprinters are concerned chiefly with the start and not so much interested in their warm-up. The hurdler usually does not have muscle pulls because he spends more time in warming up to increase flexibility.

Slager: The hurdler stretches his hamstrings every time he goes over the hurdles so he gets maximum length in all his leg muscles.

Moderator: Should there be a warm-up in every sport?

Wolfert: Yes, no question about it.

Adjustment to Heat

Moderator: Conditioning to withstand the effects of heat is very important. Dr. Turner will you describe the physiological mechanisms for adjustment to heat.

Turner: The body maintains an almost constant internal temperature throughout to a wide range of environmental temperatures. Metabolic processes occurring continuously within the cells of the body produce heat which must be dissipated. The body is a kind of furnace, continually producing heat. When the furnace is stoked because of demands for more energy, more heat is produced.

There are three basic ways by which our bodies get rid of internal heat. One is the *conduction-convection* mechanism; another is *radiation;* third is *evaporation.* Certain variable environmental factors determine the effectiveness of heat loss from the surface of the body by each of these three mechanisms. These are, (1) temperature of the air; (2) temperature of surrounding objects; (3) relative humidity; and (4) movement of the air.

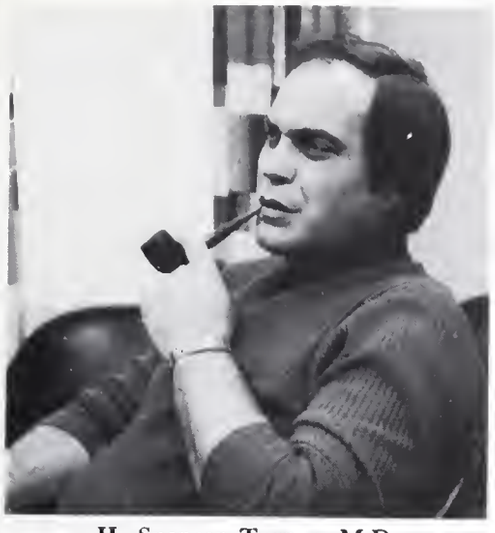
When the air temperature is lower than the skin's temperature, heat is lost by conduction through direct contact of air with the skin or the clothing. When the air is warmed in that way, it rises as it becomes less dense, replaced by cooler air. This is the convection cycle. The rate of heat loss by the conduction-convection mechanism depends upon difference between the temperature of the body's surface and that of the air. Skin temperature is normally 31 to 32 C (approximately 90 F). When the external temperature (the air temperature) equals skin temperature, no heat will be lost through conduction-convection. The converse is true, and we can absorb heat through the skin by conduction when air temperature is warmer than the body's surface.

The second variable we mentioned is radiation. The human body is constantly emitting heat radiation, but as it may also be absorbing heat, the net effect may be a heat loss or gain, depending on the temperature of the environment.

The body's third mechanism for heat regulation is evaporation. This can be extremely efficient because conversion of one gram of water from liquid to vapor (evaporation) dissipates considerable heat from the body (0.59 kcal).

The rate of evaporation depends upon the vapor pressure at the skin's surface being less than the vapor pressure in the air. When the air surrounding the body contains a lot of water (high humidity), it cannot take

*Detailed information about these warm-up procedures may be obtained by request to OSMA office.



H. Spencer Turner, M.D.

on much additional water vapor and the evaporation mechanism is not effective. Under conditions of high air humidity, the sweat simply runs off as a liquid, which does nothing at all toward cooling the body.

Moderator: What do these principles mean to the young person participating in sports?

Turner: Primary in prevention of heat injury is *acclimatization,* the process of improving loss of heat by evaporation of sweat. Acclimatization enhances all three mechanisms of heat loss to some extent but particularly improves the evaporation function. We can actually acquire ability to sweat more efficiently (more water, less electrolytes), and this helps the loss of heat and conservation of body electrolytes.

Acclimatization can be accomplished reasonably well in five to six days with proper conditioning procedures which I shall describe later. The individual will not require as high a heart rate, his blood pressure won't go as high, and he will sweat quicker and more copiously and, therefore, begin to cool more quickly. Further, the salt content of sweat becomes lower.

The second factor in avoiding heat problems is the *conditioning* mentioned previously. You not only must be *exposed* to heat for acclimatization —you must *work* in heat as well. So, it doesn't make any sense to have an athlete work out all summer in an air conditioned building or during cool evening hours. This environment would do nothing to condition his sweat mechanism for practice on a 90-degree day in mid-August.

Moderator: In addition to acclimatization, what precautions can be taken to enhance the loss of body heat?

Wolfert: Football players should wear a uniform of a white or light color because dark colors absorb more heat rays. Clothing should have short sleeves, be loose under the arms, and be made to expose the skin in the midportion of the body. A mesh weave permits air to circulate more rapidly to the skin.

We eliminate unnecessary protective pads and taping, and we have given up game stockings in favor of short sweat socks, to expose more skin for evaporation.

Lutz: The garment industry's development of synthetics that "don't breathe" has not helped. Polyesters and nylons are attractive but hot. I have noticed with girls' track teams during the past few years that many

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are wearing cotton T-shirts instead of synthetic materials.

Moderator: Girl athletes traditionally have worn skimpy clothing. We should encourage this in hot weather. For example, the girls' softball team at Ohio State University traditionally wore short shorts. There was a move recently toward wearing slacks for more protection against injuries. However, heat loss by evaporation was not so good.

Dr. Turner, would you spell out a procedure for preventing effects of heat injury.

Turner: First, be prepared to alter practice schedules, especially with football, since it involves constant activity, a high level of heat production, and heavy clothing which interferes with effective loss of heat. Most heat injuries in Ohio occur during late summer and early fall football workouts.

First, you must measure the air temperature and humidity each day. We recommend an instrument called the sling psychrometer for this purpose. It can be purchased for less than $25. It is used to determine temperature and humidity, in a simple procedure.

Second, during the first four or five days of football practice, conditioning is done in T-shirts and shorts as required by state regulations. A good practice schedule would be two hours in the morning, two hours in the afternoon, regular breaks during both practices.

Turner: In addition, use of a daily weight chart provided to all high schools by the Ohio State Medical Association requires weigh-ins before practice and weigh-outs after practices during hot weather.* Weight loss during a practice period reflects loss of water by sweating. We must be concerned especially about an individual who loses over three per cent of his initial weight during a practice session. Such people must have water at frequent intervals on the field during practice.

Note that we do not recommend salt tablets. The problem with heat injury is related solely to excessive water loss, which creates hypertonicity in the intracellular and extracellular fluid. Giving salt to an already dehydrated individual simply accentuates this problem. Salt is *not* essential during two-or three-hour workouts. The amount of sodium lost through sweat is minimal and can be replaced quite adequately and more safely at the next meal when the body has been rehydrated and can tolerate salt.

Lutz: Is a commercial electrolyte solution desirable for replacement in practices or during competition?

Turner: These preparations are basically artificial sweat. If the athlete likes them, and he takes in more fluid that way, use them. But they offer no particular advantage over plain water and no advantage in terms of available energy.



Emily E. Lutz, M.D.

Moderator: Suitable fluids with hypotonic levels of electrolytes can be made with "store-bought" ingredients.

Wolfert: The commercial products are very expensive.

Turner: A high school could spend its money to better effect by purchasing a sling psychrometer and two or three portable water pumps.

*Copies of the weight chart which includes instructions for using the sling psychrometer may be obtained by contacting the Joint Advisory Committee on Sports Medicine, c/o OSMA, 600 S. High St., Columbus, OH 43215 614/228-6971.

* * * Suggested Reading * * *

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Indications and Usage: Nalfon is indicated for relief of the signs and symptoms of rheumatoid arthritis and osteoarthritis. It is indicated in the treatment of acute flares and exacerbations and in the long-term management of these diseases. The safety and effectiveness of Nalfon have not been established in those rheumatoid arthritis patients who are designated by the American Rheumatism Association as Functional Class IV (largely or wholly incapacitated with patient bedridden or confined to wheelchair, permitting little or no self-care).

Contraindications: Nalfon is contraindicated in patients who have shown hypersensitivity to it.

Because the potential exists for cross-sensitivity to aspirin and other nonsteroidal, anti-inflammatory drugs, Nalfon should not be given to patients in whom aspirin and other nonsteroidal, anti-inflammatory drugs induce the symptoms of asthma, rhinitis, or urticaria.

Warnings: Nalfon should be given under close supervision to patients with a history of upper-gastrointestinal-tract disease and only after the Adverse Reactions section has been consulted. Gastrointestinal bleeding, sometimes severe, has been reported in patients receiving Nalfon.

In patients with active rheumatoid arthritis or osteoarthritis who also have an active peptic ulcer, attempts should be made to treat the arthritis with nonulcerogenic drugs. If Nalfon must be given, the patient should be under close supervision for signs of ulcer perforation or severe gastrointestinal bleeding.

In subacute and chronic studies in rats, Nalfon caused interstitial nephritis, glomerulonephritis, and renal papillary necrosis. These abnormalities were dose related and began to appear at doses approximating the human dose. In chronic studies in monkeys, interstitial nephritis also occurred following administration of Nalfon. Although this was seen at doses considerably above the human dose, lower doses were not studied in this species. During the course of the clinical trials, one patient developed bilateral suppurative pyelonephritis, underwent laparotomy, went on to renal failure, and died with a diagnosis of septicemia and renal papillary necrosis. It is not known whether these events were drug related. A few patients developed mild elevations of the BUN during therapy with Nalfon. Since Nalfon is eliminated primarily by the kidney, the drug should not be administered to patients with significantly impaired renal function. It is desirable to perform periodic renal function tests in all patients receiving Nalfon.

Precautions: In chronic studies in rats, high doses of Nalfon caused elevation of serum transaminase and hepatocellular hypertrophy. In clinical trials, some patients developed elevation of serum transaminase, LDH, and alkaline phosphatase which persisted for some months and usually, but not always, declined despite continuation of the drug. The significance of this is unknown. It is recommended that periodic liver function tests be performed in patients receiving Nalfon and that the drug be discontinued if abnormalities occur.

The safety of this drug in pregnancy and lactation has not been established, and its use during these events is, therefore, not recommended. Reproduction studies have been performed in rats and rabbits. When fenoprofen was given to rats during pregnancy and continued to the time of labor, parturition was prolonged. Similar results have been found with other nonsteroidal, anti-inflammatory drugs which inhibit prostaglandin synthetase.

In-vitro studies have shown that fenoprofen, because of its affinity for albumin, may displace from their binding sites other drugs which are also albumin bound and this may lead to drug interaction. Theoretically, fenoprofen, as well as other nonsteroidal, anti-inflammatory agents, could likewise be displaced. Patients receiving hydantoin, sulfonamides, or sulfonylureas should be observed for signs of toxicity to these drugs. In patients receiving coumarin-type anticoagulants, the addition of Nalfon to therapy could prolong the prothrombin time. Patients receiving both drugs should be under careful observation.

In patients receiving Nalfon® (fenoprofen calcium, Dista) and steroid concomitantly, any reduction of steroid dose should be gradual to avoid the possible complications of sudden steroid withdrawal.

Patients with initial low hemoglobin values who are receiving long-term therapy with Nalfon should have a hemoglobin determination at reasonable intervals.

Peripheral edema has been observed in some patients taking Nalfon, therefore, Nalfon should be used with caution in patients with compromised cardiac function.

Studies to date have not shown changes in the eye attributed to administration of Nalfon. However, because of adverse eye findings in animal studies with some other nonsteroidal, anti-inflammatory drugs, it is recommended that ophthalmologic studies be carried out within a reasonable period of time after chronic therapy with Nalfon has been started and at periodic intervals thereafter.

Since food decreases the blood levels of Nalfon, the drug should be given thirty minutes before or two hours after meals during the daytime.

When phenobarbital, which may enhance the metabolism of Nalfon, is added or withdrawn, dosage adjustment of Nalfon may be required.

Caution should be exercised by patients whose activities require alertness if they experience central-nervous-system side-effects from Nalfon.

Since the safety of Nalfon in patients with impaired hearing has not been established, these patients should have periodic tests of auditory function during chronic therapy with Nalfon.

Nalfon decreases platelet aggregation and may prolong bleeding time. Patients who may be adversely affected by prolongation of the bleeding time should be carefully observed when Nalfon is administered.

Adverse Reactions: *Digestive System*—The most common type of adverse reaction concerned the gastrointestinal system. Dyspepsia occurred most frequently, being observed in about one out of seven patients. Other adverse reactions, in descending order of frequency, were constipation, nausea, vomiting, abdominal pain, anorexia, occult blood in the stool, diarrhea, flatulence, and dry mouth.

Three instances of peptic ulceration and/or gastrointestinal hemorrhage that may have been due to the drug and four instances in which drug relationship was questionable were observed in 3,391 individuals to whom the drug was administered for periods of time ranging up to 165 weeks.

In less than 2 percent of patients, the drug was discontinued because of adverse gastrointestinal reactions.

Skin and Appendages—The most common adverse effect was pruritus, which was seen in about one out of ten patients. Other adverse reactions were rash, increased sweating, and urticaria.

In about 1 percent of patients, Nalfon was discontinued because of an adverse effect related to the skin.

Nervous System—The most frequent adverse reaction observed was somnolence, which occurred in about one out of seven patients. Other adverse effects, which occurred less frequently, were dizziness, tremor, confusion, and insomnia.

Nalfon was discontinued in less than 0.2 percent of patients because of these side-effects.

Special Senses—The most common adverse reaction was tinnitus, which was seen in about one out of ten patients. Other reactions observed, in descending order of frequency, were blurred vision and decreased hearing.

In about 0.2 percent of patients, Nalfon was discontinued owing to adverse effects related to the special senses.

Cardiovascular—The most frequent adverse effect observed was palpitations. This was noted in about one out of twenty-five patients. Tachycardia was observed less frequently.

In less than 0.5 percent of patients, Nalfon was discontinued as a result of cardiovascular adverse reactions.

Laboratory—Anemia was noted in about one out of 500 patients. Therapy with Nalfon had to be discontinued in one patient because of anemia. Increase in alkaline phosphatase, LDH, and SGOT was observed (see Precautions).

Miscellaneous—Headache was seen in about one out of seven patients. Less frequently observed, in descending order of frequency, were nervousness, asthenia, dyspnea, peripheral edema, fatigue, malaise, and dysuria. [031677]

Additional information available to the profession on request

DISTA
700452

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Editor's Note: Due to a typesetting error, page 331, paragraph 2, sentence 1 should read "PICO's policies are offered on a $100,000 per claim, $300,000 aggregate per year basis and provide "occurrence" rather than "claims-made" type coverage."

REPORT OF THE TASK FORCE ON PROFESSIONAL LIABILITY

TO THE MEMBERSHIP OF THE OHIO STATE MEDICAL ASSOCIATION

Members of Task Force

James L. Henry, M.D. chairman
George N. Bates, M.D.
Maurice F. Lieber, M.D.
A. Burton Payne, M.D.
Robert G. Thomas, M.D.
William M. Wells, M.D.

PREFACE

The OSMA Task Force on Professional Liability was formed by the Council of the OSMA early in 1975. The members were the officers of the Association and reported directly to the Council. This Task Force was charged with the appraisal of the liability insurance crisis facing thousands of members of the Association. This original Task Force spent many hours in deliberation with a like committee from the Ohio Bar Association. In addition, many meetings were held with actuaries, legal counsel, insurance company representatives, and government officials.

From the information and appraisals made by this Task Force, many of the provisions contained in H.B. 682 were first formulated. Recognizing the limitations of such a group, an advisory committee of several speciality organizations was formed. This committee did and continues to provide a broader input into the formulation of policy recommendations by the Task Force. Indeed, this group's activities have been most instrumental in providing active support and assuring accomplishment of the Task Force's goals. The Task Force at this point in time existed as an instrument of the Council of OSMA.

In 1976, the Task Force on Professional Liability was enlarged to include members who were neither officers nor councilors of OSMA. At this point, practically speaking, the Task Force became a committee of the House of Delegates. This is emphasized by Substitute Resolution No. 45-76 adopted by the OSMA House of Delegates in May, 1976. The final resolve states, "That the Ohio State Medical Association Task Force on Professional Liability be funded by voluntary solicitation of the OSMA membership." This action indicates that the Task Force is indeed not a committee of Council but of the House and Association as a whole.

Research Projects

This resolution further provided sorely needed money to finance the recommended actions of the House of Delegates and the Task Force. These recommendations included research and action upon such items as: a) Court Docket Survey; b) Counterclaims; c) Captive Insurance Company; d) Actuarial Analysis; and e) Public and Professional information campaigns. The status of these programs has been delineated in this document.

At this point, the Task Force assumed that it could proceed precisely as it had done prior to the receipt of the voluntary contributions. Basically, this meant the utilization of the resources of the Association including personnel, facilities, and expertise. However, both the auditors and legal counsel for OSMA warned that the money of the OSMA Malpractice Research Fund could not be mingled with the money of OSMA. To do so could create serious tax problems for both the Association and the contributors to the research fund.

This seemed to indicate an immediate necessity to form and develop an entirely new organization to fulfill the Task Force's directives from both Council and the House of Delegates. Careful evaluation dictated that, because of time constraints and economic feasibility, it would be utter folly to create a new organization. Development of an appropriately educated staff could indeterminately delay imperative actions plus expend a great deal of money.

In order to meet the needs in a timely fashion and to attack the charges directed to it, the Task Force became a "quasi" independent organization within the structure of OSMA. In this manner, the Task Force became responsible for the custody and expenditure of the funds contributed to the OSMA Malpractice Research Fund to assure that the desires of the membership were fulfilled.

To this end, the Task Force chose to establish a working relationship with OSMA rather than structuring a similar organization. The Task Force requested that the facilities, services, and personnel of OSMA be made available to it on a reimbursable basis. The Task Force agreed to provide reimbursement to OSMA on an actual and allocated cost basis. Both parties accepted these provisions. The Task Force agreed, in its dealings with the Council of OSMA, to follow the policies and procedures that OSMA had established in conducting its affairs. This insured fiscal integrity and accountability for both.

Expenditures for all services provided either by OSMA or other contracted organizations have been and continue to be approved by the Task Force. These approved expenditures are transmitted to the Auditing and Appropriations Committee of OSMA, and their recommendations are transmitted to the OSMA Council. The recommendations of these bodies are given the careful consideration of the Task Force. It is important to note that the Council of OSMA cannot and does not initiate the expenditure of the Malpractice Research Fund money. This is the basic responsibility of the Task Force, which is constantly aware of its role and reacts in a prudent manner.

Indeed, amended resolution 45-76 provides the necessary finances to proceed on a purposeful course. The Task Force on Professional Liability firmly holds to the concept that the money entrusted to it by the voluntary contributions of 22% of the OSMA membership are not intended to subsidize the operation of OSMA, PICO, or any affiliated group of OSMA. The Task Force is appropriately aware that its function cannot and must not jeopardize the fiscal integrity and obligations of the Ohio State Medical Association at large.

The Professional Liability Task Force, by virtue of Resolution 45-76, has an overall commitment to the entire membership of OSMA, but it has a particular obligation to the more than 2,400 contributors to the Research Fund. OSMA has a primary obligation to each of its members, and an important secondary obligation to the members who contributed to the Research Fund.

This comprehensive report is intended to demonstrate precisely how both the Task Force and the OSMA Council have responded to the charges given them by the House of Delegates and the membership of the Ohio State Medical Association. The Task Force and OSMA Council are acutely aware of their particular responsibilities in solving the continuing problems presented by professional liability and present this report not so much as an end but rather as a beginning.

James L. Henry, M.D.

James L. Henry, MD, Chairman,
March 10, 1977
Task Force on
Professional Liability

MALPRACTICE RESEARCH FUND
STATEMENT OF OPERATIONS
APRIL 1, 1976 TO MARCH 14, 1977

Deposits:			
Contributions*		$238,631.00	
Interest		5,818.96	$244,449.96
Disbursements:			
Management Horizons, Inc.:			
Consulting Services	$14,000.40		
Expenses:			
Miscellaneous	355.64		
Court Docket Survey	1,625.52		
Public Attitude Survey	754.91	$ 16,736.47	
Gebhardt Associates Printing		2,455.51	
Dwight Spencer & Associates			
Interviews: Public Attitude Survey		15,250.00	
Miscellaneous Disbursements		230.30	
Legal Fees		29,522.75	
Actuarial Services (Tillinghast of Atlanta)		5,381.93	
Administrative Services Reimbursed to OSMA:			
Solicitation & Generation of Fund		9,167.81	
Administration & Control		13,114.46	
Court Docket Survey		266.67	
Malpractice Insurance Company Project		31,430.26	
Actuarial Analysis Project		2,848.29	
Public Attitude Survey		1,520.00	
Special Session House of Delegates		2,513.00	
Postage & Mailing Expense		9,274.65	
Staff Expense: OSMA		6,922.62	
Printing & Supplies		5,586.16	
Telephone Expense		575.77	
Ohio State Medical Journal			
(information page & survey forms)		900.75	
Miscellaneous Supplies & Expense		1,148.14	
Coopers & Lybrand (accounting services)		250.00	
TOTAL DISBURSEMENTS			155,095.54
Dollar Savings		$ 89,333.25	
CNB Checking Acct.		621.17	
Less Account Payable			
Tillinghast (actuarial firm)		600.00	
BALANCE ON DEPOSIT: 03-14-77			$ 89,354.42

*2482 Contributors, 22% of OSMA Membership

1976 OSMA HOUSE OF DELEGATES RESOLUTIONS PERTAINING TO PROFESSIONAL LIABILITY

During the 1976 Annual Meeting of the OSMA, 17 resolutions dealing with various aspects of professional liability were submitted to the House of Delegates for action. Eleven of those resolutions had direct bearing on the activities of the Task Force. The eleven resolutions were combined into four resolutions which were submitted to and subsequently approved by the House.

The resolutions are as follows:

Legal Redress

Amended Substitute Resolution No. 6-76
Legal Redress

WHEREAS, A substantial number of medical malpractice suits are filed in Ohio each year; and

WHEREAS, The rising costs of professional liability premiums have contributed to the increased cost of medical care, and have encouraged defensive medicine; and

WHEREAS, To date there has been no effective deterrent to the large number of mischievous and frivolous professional liability claims being filed against sincere, honest and competent physicians, THEREFORE BE IT

RESOLVED, That the OSMA Council take positive action to encourage, sponsor, and endorse legal action to permit a physician to seek redress in the event that the physician was named as a defendant in a lawsuit when an ordinary review of pertinent medical records and other evidence would have shown that the defendant was not a party to the proximate cause of the incident that is the subject of the dispute; and BE IT FURTHER

RESOLVED, The Ohio State Medical Association Council should encourage and support action to establish the principle that if the defendant is found not liable in a malpractice action, the payment of all court costs and attorney fees of both plaintiff and defendant will be the responsibility of the plaintiff AND THE PLAINTIFF'S ATTORNEY; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association Council should actively develop and sponsor legislation and procedural rules which would have the following provision: In any action for damages for personal injury or death, whether based on tort or contract law, a counterclaim for damages for abuse of process in filing such action may be filed and litigated in the same action.

Captive Company

Amended Resolution No. 8-76

WHEREAS, The establishment of a JUA has not encouraged private insurance carriers to remain in the medical professional liability insurance market; and

WHEREAS, Two major medical professional liability insurance carriers have refused to renew the policies of physicians in this State; and

WHEREAS, The American Medical Association has formed a reinsurance company that will guarantee a reinsurance market for captive insurance companies in this and other states; and

WHEREAS, The Ohio State Medical Association Council has already established a task force to consider the formation of a captive company; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Council shall co
search the feasibility of forming a health care provider-owned insurance c
shall report their recommendations to the House of Delegates of the OSM
possible.

Professional Liability Data

Substitute Resolution No. 21-76
Professional Liability Data

WHEREAS, Statistics should be gathered to demonstrate the cost of medica
sional liability insurance and its impact on the cost of health care to the citize
State and to study pertinent data on suits alleging medical malpractice, and

WHEREAS, No factual data have been published by the Ohio Department of Insurance to substantiate insurance rate increases; and

WHEREAS, Increased costs for insurance are reflected in increased costs for medical services or potential curtailment of medical services; and

WHEREAS, The Ohio State Medical Association Council has followed the directive of the 1975 OSMA House of Delegates in Substitute Resolution No. 2-75, Professional Liability, and has taken appropriate action to form the Task Force on Professional Liability; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Council be commended for their action and instructed to continue their efforts in this direction.

Countersuits and Malpractice Action

Resolution No. 45-76
Special Assessment for Proposed Countersuits and
Emergency Resolution 48-76
Council Implemented Malpractice Action Program

Finally, the last two resolutions considered by this Committee were Resolution No. 45-76 and Emergency Resolution 48-76. The Committee felt that these resolutions were addressed to very important aspects of OSMA Task Force assessments and countersuit financing. After much discussion, it was decided to present the following substitute resolution:

Special Assessments

Substitute Resolution No. 45-76
Special Assessments

WHEREAS, A substantial number of medical malpractice suits are filed in Ohio each year; and

WHEREAS, The filing of these frivolous and malicious suits constitute a constant harassment to physicians; and

WHEREAS, The Council of the Ohio State Medical Association, through its Task Force on Professional Liability, has seen fit to launch a major investigative fact-finding program to hopefully help solve the malpractice problem in the State of Ohio; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Council be directed to establish a mechanism to advise, assist and support Ohio physicians regarding countersuits against such party or parties who, in the opinion of OSMA Legal Counsel, have initiated baseless and frivolous professional liability proceedings; and BE IT FURTHER

RESOLVED, That the OSMA Council be commended for their work to date and be reminded of their responsibilities regarding timely reports to the OSMA membership; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability be funded by voluntary solicitation of the OSMA membership.

INTRODUCTION

Early in 1976, the Task Force on Professional Liability began working closely with representatives of various specialty societies in Ohio. A series of meetings was held, and it became obvious that information the Task Force had been seeking from attorneys, insurance companies, and other sources in regard to the professional liability situation had not been and would not be provided immediately.

The Task Force, for some time, had sought answers to such questions as: How many malpractice suits have been filed against Ohio physicians during the past five years? What type of physician is being sued? How have cases been resolved and for how much money? What percentage of the settlement actually goes to the patient and how much to the attorney?

The Task Force determined at this point that the only way to gain access to the data was to seek out alternative methods for obtaining it.

On April 21, 1976, the Task Force mailed out the first of three solicitation letters to all members of the OSMA. A series of research projects had been designed which would provide the Task Force with the needed data. The series included: a Court Docket Survey, a Counterclaim Research Project, investigation into the feasibility of a Captive Malpractice Insurance Company, an Actuarial Analysis, and an intensive Public Education Campaign.

The Task Force requested that each member voluntarily contribute $100 toward the implementation of these projects. As soon as contributions began to arrive, the Task Force began allocating resources toward the implementation of these projects. Each expenditure was approved by the OSMA Council which was kept fully informed at all times as to Task Force activities. A chronological history of each project, its outcome, and the expenditures on each are discussed on the pages that follow.

Solicitation and Generation of Fund $26,323.70 (17%) Administration and Control $28,288.68 (18.2%).

CAPTIVE MALPRACTICE INSURANCE COMPANY

PUBLIC EDUCATION CAMPAIGN

CAPTIVE MALPRACTICE INSURANCE COMPANY

The Task Force met many times to investigate all the various alternatives available for providing professional liability insurance at a reasonable cost to OSMA members. After looking at various programs in other states, the Task Force concluded that it was indeed feasible to create a "captive" company and began looking at several mechanisms for such formation. The Task Force looked at three basic designs: (1) the formation of a mutual, (2) the formation of a reciprocal, and (3) the formation of a profit-oriented stock company.

Mutual insurance companies have been formed by other state medical associations and have advantages, but the Task Force learned that capitalization by such companies had been very difficult because the contributions were generally viewed as a non-investment activity. Reciprocals have also been formed by some other state medical associations, but Ohio law is somewhat unique with regard to reciprocals in that, in Ohio, a reciprocal does not enjoy the protection of the Ohio Insurance Guarantee Association. The purpose of the Ohio Insurance Guarantee Association is to protect policyholders in case of insolvency on the part of a carrier. All stock insurance companies in Ohio must participate in the Association, and by so doing, they agree to honor the commitments of any member of the Association who might become insolvent. Reciprocals, because they do not enjoy this protection, are, therefore, assessable, and the Task Force felt this assessability feature was not desirable nor advantageous to the majority of OSMA members.

Finally, the Task Force in reviewing the formation of a stock company, felt that physicians in Ohio would be more willing to invest in a capitalization venture if the program were handled in a business-like manner and if the investment showed a good possibility of a profitable return.

For-Profit Stock Company

Therefore, on June 23, 1976, the Task Force recommended to the Council "that a professional liability company be formed to provide the OSMA membership with an alternative source of professional liability insurance." On June 29, the Council approved the Task Force's recommendation, which concluded that the company should be a for-profit, stock company, and on August 1, during a special session, the OSMA House of Delegates gave final approval for formation of such a company.

After the House of Delegates' meeting, the Task Force was instrumental in assisting early development of the physicians' new insurance company — Physicians Insurance Company of Ohio (PICO). Since the House had demanded strong leadership management be obtained, Mr. Joseph K. Gilmore, then Deputy Director of the Ohio Department of Insurance, was approached and agreed to become its first President. PICO's offering circular was mailed to all OSMA members on September 15, 1976, and stock sales began immediately. Thus, PICO was created as a viable solution to the insurance "crisis."

Twelve thousand shares of Class A Common Stock were offered to members of the OSMA at $1,000 per share. One hundred shares of Class B Common Stock were sold to the OSMA at the same price. Both shares have identical rights except that (a) the Class A Shares have one vote per share while the Class B Shares have one hundred votes per share and (b) Class A Shares must be offered back to the Company in the event that a shareholder desires to sell or transfer his shares.

Any member of the OSMA is eligible to apply for professional liability insurance. Each applicant must purchase a number of shares of stock equal to his risk classification, as determined by PICO's underwriting structure. The maximum number of shares any single applicant is required to carry is five. Medical partnerships or corporations applying for insurance must purchase the number of shares equal to the aggregate risk classifications of all employees or partners to be insured.

By the first week of December, it was apparent that many physicians were desirous of purchasing insurance from PICO but were hesitant to participate in the capitalization

program. Because of this, the OSMA borrowed funds and purchased $1,500,000 worth of PICO stock and completed capitalization of the company. Within three weeks, the OSMA sold its PICO stock to newly subscribed physicians and the loan obligation was promptly retired.

Because of OSMA's activities in early December, 1976, the minimum capitalization required by Ohio law was achieved, and PICO's first shareholders meeting was held December 26, 1976. The Board of Directors suggested by the Task Force was elected at that time. The Ohio Department of Insurance issued PICO its license to sell property and casualty insurance on December 27, 1976, and PICO began binding insurance contracts that same day. Through January and February of 1977, PICO issued 845 policies, mailed 1,200 quotes, and achieved total stock sales of $3,841,000. Based upon these figures, PICO management expects to have approximately 3,500 insureds by the end of calendar year 1977.

PICO's policies are offered on a $100,000 per claim, $300,000 aggregate per year basis and provide "claims-made" type coverage. This type of coverage was strongly requested by the House of Delegates. The consent of the insured physician is required to settle a claim.

Medical Premium Finance Company Physicians Insurance Agency

In addition to the above activities, PICO has formed two wholly-owned subsidiary companies to further assist OSMA members. Medical Premium Finance Company was formed December 27, 1976, and currently provides financing mechanisms for physicians who wish to pay their professional liability insurance premiums on an installment basis. Medical Premium Finance Company was capitalized by PICO and serves as one of PICO's investment programs. Physicians Insurance Agency was also formed on December 27, 1976, and currently provides a service mechanism to persons having their primary professional liability insurance with PICO and desiring excess insurance through the Joint Underwriting Association. This subsidiary is licensed by the State of Ohio to act as an insurance agency but limits its activities solely to the placement of this excess insurance.

Excess insurance remains one of the problems which the Task Force hopes to assist in solving during the upcoming year. PICO will not be able to sell an excess policy until adequate reinsurance capacity can be obtained. The reinsurance marketplace, which for the past few years has been extremely tight, is currently showing signs of loosening. The AMA, through a sponsored program with Kemper Reinsurance Company, is attempting to provide reinsurance assistance, and other sources of reinsurance may be provided through the Joint Underwriting Association (JUA) or the Stabilization Reserve Fund (SRF). The Task Force will continue to work on this project with the help of PICO management.

Cost of project: $49,036.32 (31.6%)

PUBLIC EDUCATION CAMPAIGN

"Ripple Effect"

Information gathered by the Task Force strongly suggested that the professional liability situation was having a serious "ripple effect" throughout the entire health care delivery system. Physicians found they had to raise fees to cover the cost of increased premiums and found themselves practicing "defensive medicine" as added protection against the threat of malpractice litigation. It became clear to the Task Force that the general public would have to be educated to the fact that professional liability is not just a physician's problem, but one to be shared by both consumers and providers of health care.

Several plans of action were discussed, but it became apparent that an empirical basis of information about public attitudes toward the medical profession, in general, and professional liability, in particular, was necessary. The Task Force felt that it would be unwise to rely entirely on secondary and out-of-state sources of information, expert opinions, and analyses of component issues in planning a public education campaign. It also became apparent that this basis of information was critical to other projects, such as the court docket survey and actuarial analysis. Therefore, on June 3, 1976, the

Task Force signed a contract with a consultant firm specializing in consumer marketing, Management Horizons, Incorporated. Management Horizons began at once to develop and coordinate Task Force activities to acquire meaningful needed information.

As a first step toward determining public attitudes toward medicine, the Task Force approved a public opinion survey to be conducted via telephone to a random sample of 1,500 adult residents in Ohio at a cost of approximately $16,000.

The survey was completed in late November and presented to the Task Force at its December 1 meeting. It was then referred by the Task Force to the Committee on Public Relations for further study and implementation.

On January 19, 1977, the Committee on Public Relations met with Roger Blackwell, PhD., of Management Horizons, to evaluate and discuss implementation of the data.

Based on that discussion, the Committee made five recommendations to the Task Force and the Council, which were approved by Council on February 18. The recommendations and current status of each are as follows:

Recommendations

1. The Public Opinion Survey is being sent, in its entirety and at no charge, to all OSMA members who contributed to the Malpractice Research Fund. It is being made available to all other members for $9.95. In addition, the Survey is being sent to key officials such as state legislators.

2. A presentation of the Survey and a discussion as to its implications for physicians and the general public is being presented during a special general session at the 1977 OSMA Annual Meeting, Monday, May 16, 1:30 p.m. - 3:30 p.m. at Veterans Memorial Auditorium. To encourage attendance, a special preview of the session is being presented during the Sunday evening opening session of the House of Delegates. To capitalize on the wealth of valuable information this report has for the public, a major press conference is scheduled for 10:00 a.m. Monday, May 16, with not only Ohio media, but with national media outlets, such as *Medical Economics* magazine, Physicians' News Service, and so on in attendance. Detailed press kits, which will include the highlights booklet, will be distributed to those reporters in attendance. In addition, appearances by Dr. Blackwell are scheduled for various television stations, newspapers, and radio stations.

3. A presentation is being developed for medical students to inform them as to the kinds of issues and problems which will face them as physicians and suggestions for handling these problems. This is to be completed by May 15.

4. A two-day seminar is tentatively scheduled for early September for all county public and community relations chairmen. The purpose is to begin an intensive grass roots public relations effort, using the information and insight provided by the survey. Dr. Blackwell will present suggestions for grass roots public relations programs, and OSMA will discuss the current programs being conducted and those being planned in this area.

5. A 32-page booklet highlighting the important points in the survey is being developed for distribution to the public, statewide media, and to physicians for use in their waiting and examining rooms. The booklet will be distributed to the news media during the Monday morning press conference.

Following the Council's approval, the Auditing and Appropriations Committee approved a $25,000 request to implement these projects, all of which will be completed and presented except for the Public Relations Seminar, during the Annual Meeting.

Also planned is a series of academic and general articles featuring the highlights of the Survey which will be presented in such publications as *Public Opinion Quarterly*, various medical and specialty journals, and general public magazines.

Cost of project: $27,162.31 (17.5%).

COUNTERSUITS

COURT DOCKET SURVEY

ACTUARIAL ANALYSIS

COUNTERSUITS

Both Resolution 6-76 and the mandates of the House of Delegates passed during its special session on August 1, 1976, placed responsibility on the Task Force to develop and implement an appropriate countersuit program for physicians who believe they have been wrongly sued for medical malpractice.

The Task Force has carried out its charge in the following manner.

First, it has developed a mechanism to assist physicians and their personal attorneys in reviewing facts and making recommendations with respect to countersuits. A more detailed description of that review mechanism follows later.

Secondly, OSMA has intervened as *amicus curiae* in a countersuit filed in Cuyahoga Common Pleas Court by a physician against his former patient and attorney. The Cleveland Academy of Medicine has also intervened *amicus curiae* in that case, and it is the hope of both groups that intervention into that case may ultimately lead the Ohio Supreme Court to adopt a more liberal view of malicious prosecution in order that the physician wrongly sued for malpractice will be freer to seek legal redress.

Thirdly, the Task Force is continuing to investigate the possibility of legislative or judicial changes that would permit a countersuit to be instituted in the primary malpractice case where there is evidence that the malpractice action was filed and/or prosecuted maliciously. Unfortunately, no sponsors for such legislation have as yet been found. The Governor's Task Force on Professional Liability refused to accept proposed amendments that would permit countersuit activity concurrently with the primary action. Nor has there been movement by the Ohio Supreme Court to accept a procedural rule similar to the rule in Illinois which permitted Dr. Berlin, in his well-known case, to successfully obtain a judgment in the trial court against his former patient and his lawyer. It should be noted, however, that Dr. Berlin's case is now on appeal and many legal observers fear that the judgment in favor of Dr. Berlin may be reversed on appeal.

The Task Force is satisfied that the countersuit activities by Ohio physicians, spurred by Dr. Berlin's success in the trial court and supported by the Task Force, have already been productive. There is evidence that many patients and their counsels have decided not to file medical malpractice cases or have dismissed them upon learning of the facts and of the doctors' firm resolve, in appropriate cases to assert countersuits. In short, many lawyers are becoming aware of the potential of countersuits by physicians who believe they have been wrongly sued, and they and their clients are becoming more careful in the filing and prosecution of frivolous and non-meritorious lawsuits.

With regard to the review mechanism, many members have submitted potential countersuit cases to the Task Force and a full review of them has been carried out. Although the Task Force and OSMA will not become directly involved in any countersuit (except as noted above as *amicus curiae*), they will perform, as a service to the membership, a general review and research function in those instances in which the physician is considering a countersuit.

Review Mechanisms and Countersuit Guidelines

The Task Force has set up the following review mechanism and countersuit guidelines to assist members who are considering countersuits.

Four conditions should be met before a potential countersuit can be seriously considered:

1. The original malpractice suit should be dismissed without payment to the patient;
2. There should be evidence of malice on part of the patient and/or his attorney;
3. There should be a lack of probable cause, in the original suit; and
4. There should be some injury or damage sustained by the physician.

Any member who feels he has a meritorious countersuit, under the above guidelines, should have his personal attorney submit the following documents and information to the Task Force:

1. Copy of complaint and answer and other pertinent pleadings in the original action;
2. Medical documentation; such as progress notes, case history, etc.;
3. Interrogatories, depositions, requests for admission, etc.;
4. Court orders;
5. Names of all attorneys involved;
6. Names of insurance carriers involved; and
7. Any additional relevant information.

After the Task Force receives this information, an initial analysis will be made by the Task Force staff. It will then be sent to OSMA legal counsel who will, on behalf of the Task Force, make a recommendation as to the legal merits of a proposed countersuit. The recommendations of both the Task Force and legal counsel will then be sent to the physician and his attorney.

Should both recommendations be that the countersuit may be meritorious, the Task Force may recommend to the OSMA Council that legal counsel provide additional assistance to the physician after the lawsuit is filed. This would be the exception and not the rule. Should the Task Force and legal counsel determine that there are insufficient grounds for a counterclaim, neither the Task Force nor OSMA legal counsel will assist further. The physican would be free to pursue the countersuit with his own attorney at his own expense.

Cost of project: $8,283.19 (5.4%).

COURT DOCKET SURVEY

At the time that House Bill 682, the Omnibus Medical Malpractice Bill, was being debated in the legislature, the OSMA made repeated requests to insurance companies, lawyers, the courts, and others for information on liability statistics. No viable information was forthcoming. On March 13, 1976, the Task Force recommended and the OSMA Council approved the concept of pretesting a Court Docket Survey in Franklin County in an attempt to develop liability statistics which would be useful in pursuing such activities as counterclaims, legislation, a physician-owned insurance company, and so on.

Franklin County Pretest

The Survey was conducted by Management Horizons as part of the five Malpractice Research Projects instituted by the Task Force. Cases filed in Franklin County Court of Common Pleas during the three-year period between July 1, 1973 and July 1, 1976 were used in the pretest. The purpose of the pretest was to determine the value and feasibility of conducting a more comprehensive Court Docket Survey throughout the state.

The Task Force was able to gather the following information through the Franklin County pretest:

1. The number of cases involving physicians, if original notation of "M.D." is designated.
2. There is substantial concentration among attorneys involved in medical malpractice cases regardless of whether they are plaintiff or defendant attorneys. However, contrary to popular belief, the concentration is greater among defendant attorneys than among plaintiff attorneys. In fact, it was found that most malpractice suits are brought by attorneys for whom medical malpractice cases are not an important part of their total practice. It was found that most plaintiff attorneys in medical malpractice suits handle only one case per year and are unlikely to handle any malpractice cases in subsequent years. On the other hand, it was found that defendant attorneys

who handle only one case per year tend to reappear on the list in subsequent years with more frequency than do plaintiff attorneys.

When analyzed on the basis of law firms rather than individual attorneys, the survey shows there is a great deal of concentration among defendant law firms. This may be due to a particular firm's relationship with an insurance carrier.

In the case of plaintiff firms, the survey shows that while a few firms account for a disproportionate number of malpractice cases (38.5%), the majority of cases (61.5%) is spread across many individual attorneys.

3. The mean amount of the "prayer" was as follows:

1973	$319,459
1974	308,509
1975	514,642
1976	186,877 (6 month period)

4. Among physician specialties, the largest number of claims during the time period of this study was in the specialty of Obstetrics and Gynecology with Orthopedic Surgery and General Surgery second and third respectively.

5. The most frequent basis or cause for filing a malpractice suit was based on the charge of physician "negligence in diagnosis/treatment." Other frequently cited causes were "below standard of skill, knowledge, and care," and "uninformed consent." It is important to note, however, that court files are relatively unproductive sources of specific information about the basis of malpractice claims because of the practice of most attorneys to list a standard basis rather than specific cause for the charge.

6. Most cases were settled "with prejudice," meaning the case cannot be refiled, rather than "without prejudice," meaning the case may be refiled.

The Task Force found that it was not possible to obtain the following information from a Court Docket Survey:

1. The final settlement amount in all cases, although the results of jury verdicts, including the amount awarded to the plaintiff in plaintiff's verdicts, is available.
2. The dollar amount of the settlement received by the plaintiff and the amount received by the plaintiff's attorney. A telephone follow-up was attempted to determine additional data. The plaintiff agreed to talk to the telephone interviewer in only 2% of the cases contained in this survey. It is obvious that former plaintiffs are not willing to discuss previous litigation and to pursue this matter further would not be cost effective.
3. Court Docket surveys are expensive, particularly when a measurement is made regarding the useful information obtained from the Court Docket survey which is not available from other sources. Membership surveys provide better data than do Court Docket surveys.
4. Complete, accurate identification of every malpractice case filed against a physician is not possible since the Plaintiff-Defendant Index does not always differentiate one type of "doctor" from another or whether the case being filed is a malpractice case or some other type of suit.
5. It is nearly impossible to ascertain, from public records, the outcome of malpractice suits because most are settled and dismissed without going to trial. Thus, settlements are not public information.

Conclusions

The Task Force concluded that:

1. The procedures developed for the Franklin County survey can be implemented on an expanded basis in other portions of the state with the anticipation of no major problems.

2. Reliable data can be obtained measuring the trends in number of malpractice suits filed. These data can be classified by time period, geographic unit, cause of action, and some other variables.

3. Reliable data can be obtained measuring the concentration of representation by plaintiff and defendant attorneys and law firms.

4. Considerable data can be obtained about the operations or treatments that most frequently result in malpractice suits. This data might be of substantial value in designing internal education and information programs, providing the data are analyzed by qualified medical personnel.

5. Reliable data cannot be obtained about the outcomes or settlements or settlement proportion to plaintiff attorneys from public records or a follow-up telephone survey of plaintiffs.

It appears as though the Franklin County Court Docket Survey has served a useful purpose in determining what information can and cannot be obtained through this method. The data from the Franklin County pretest can be used throughout the state without conducting further surveys.

The Task Force determined that a Court Docket Survey is not a productive data source on a cost effective basis. The survey does provide a model method for conduct of such surveys as may be desired by a component medical society.

Cost of the project: $5,403.33 (3.5%)..

ACTUARIAL ANALYSIS

As with the Court Docket Survey, the Task Force made repeated requests for actuarial information from insurance companies, but this information was not forthcoming. It became apparent that viable actuarial statistics were needed which would allow the OSMA to challenge any proposed malpractice rate increases by insurance companies or their filing services. Without this data, Ohio's physicians have little defense when rates continue to escalate.

Rate Increases Successfully Challenged

The Task Force, as part of its ongoing responsibilities, closely monitored the insurance climate in Ohio. In August 1976, the Insurance Services Organization (ISO), the rate filing service for insurance companies, proposed a 145% increase in professional liability insurance to the Ohio Department of Insurance. The Task Force responded by saying that such increases would have a significant impact on the cost of medical services to consumers and challenged the proposal, asking the Department of Insurance to conduct public hearings on the increases. The Task Force also requested that its own actuarial consultants analyze the data filed by ISO. The Task Force concluded that the rate increases requested in the filing were both inappropriate and unnecessary. Subsequently ISO withdrew its filing.

The Task Force has retained an ongoing relationship with professional actuaries who are capable of analyzing any proposed insurance rate increase and evaluating the necessity of the proposed increase according to Ohio data and the continuing studies of the National Association of Insurance Commission. Discussions are continuing with the Ohio Department of Insurance in an effort to assure that data retrieved are meaningful.

Cost of project; $10,598.01 (6.8%).

Medical Malpractice Suit Questionnaire

Although the Court Docket Survey provided much valuable information, the Task Force felt strongly that additional statistical information was needed which could be used toward counterclaim activities, public education programs, and in continuing actuarial analysis efforts. The Task Force felt that the best way to gather the needed information was to question physicians themselves.

A questionnaire on Medical Malpractice Suits was designed and placed in the August issues of both the "OSMAgram" and the *Journal*. Physicians were asked to provide information on any liability suits in which they had been involved during the period between January, 1970, through July, 1976. Also requested was information such as the names of both the plaintiff and plaintiff's attorney, the defense attorney, date the suit was filed, the disposition and outcome of the case, amount of award or settlement, name of insurance company, and so on. The Task Force emphasized that the information obtained through the Survey would be kept in strictest confidence. Therefore, only general information will be printed here.

Nearly 50% of the OSMA membership responded to the questionnaire, with a total return of 4,427. Of that number, 3,751 indicated they had not been sued during the five and a half year period, with 676 indicating they had been sued at least once during that period.

The largest number of respondents indicated Family Practice as their specialty. Out of the 1,115 Family practitioners who returned questionnaires, 57 indicated having been sued. This was followed by Internists with 698 respondents and 54 indicating having been sued. Of the 587 General Surgeons who responded, 130 indicated having been sued. Obstetricians/gynecologists followed, with 340 respondents and 91 indicating having been sued. Ninety-one Orthopedists responded, with 63 indicating having been sued.

The following chart provides a breakdown, by specialty, of the respondents who were and were not sued.

Total: Sued and Non-Sued	Sued	Non-Sued	Total
Allergy	2	38	40
Anesthesiology	36	69	105
Cardiology	2		2
Dermatology	3	58	61
Emergency Room	5	3	8
Family Planning		1	1
Family Practice	57	1058	1115
Gastroenterology		3	3
General Practice	50		50
Geriatrics		6	6
Internal Medicine	54	644	698
Neurology	8	30	38
Neurosurgery	19		19
Nephrology	1	1	2
Nuclear Medicine	1		1
Obstetrics/Gynecology	91	249	340
Occupational Medicine		27	27
Orthopedic Emergency	1		1
Ophthalmology	17	180	197
Orthopedics	63	28	91
Otolaryngology	17	71	88
Pathology	7	147	154
Pediatrics	9	200	209
Physical Medicine		14	14
Plastic Surgery	9		9
Preventive Medicine		2	2
Psychiatry	13	215	228
Public Health		10	10
Pulmonary Disease	4	6	10
Radiotherapy	4		4
Radiology	43	151	194
Rheumatology	1	2	3
Surgery	130	457	587
Thoracic Surgery	12		12
Urology	16	81	97
Vascular Surgery	1		1

Many of those responding were unable to provide information as to the disposition and outcome of the case because the great majority of them are pending, some for as long as three years. Many physicians indicated frustration with this aspect of the suit, saying that although they had been notified they were being named in a suit, many had heard nothing more about it. Therefore, because of the "pending" aspects of many suits, figures as to outcome and disposition will not correlate with the number of suits filed. Those whose suits had been settled indicated the following:

DISPOSITION OF CASE		OUTCOME	
Went to binding arbitration	23	Verdict for Plaintiff	19
Went to Trial	93	Verdict for Defendant	69
Went to Jury	86	Dismissed	138
Went to Non-Jury	7	Settled out of court	220

When asked if the insurance company settled without the physician's permission, 51 indicated yes and 337 indicated no.

A complete, in-depth analysis of the questionnaire will appear at a later date in the *OSMA JOURNAL*.

Cost of project: $900.75

SUMMARY

This report from your Task Force on Professional Liability is intended to provide a status report on the projects assigned to it by the House of Delegates and the Council of OSMA. The tasks have been large and in some cases difficult to accomplish. Some, such as the professional and public information programs, must be ongoing. Countersuit actions need a great deal of work to make them more effective and productive as a tool in the fight against non-meritorious law suits.

Monitoring of actuarial data must be ongoing and programmed so that it will produce useful information. Through the resources of PICO, much information will be obtained, but a great deal of it will not be useful for three to five years. The Task Force will continue to gather data compiled by the Ohio Department of Insurance.

The Court Docket Survey did not provide the expected information and seemed to indicate that as a specific source it was not a cost effective means. However, it did provide an excellent prototype for the conduct of such surveys.

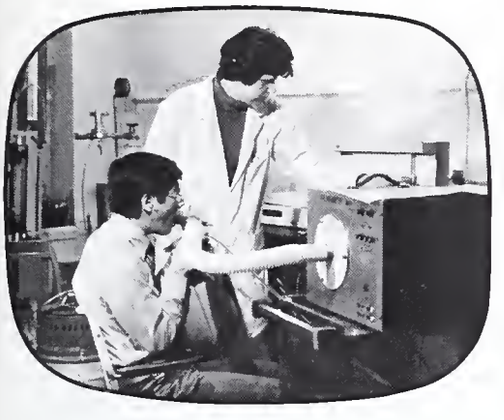
The Task Force is most appreciative of the cooperation provided by OSMA members in compiling much of this information. This cooperation demonstrates that the physicians are sincerely dedicated to solving the liability problem.

The Task Force will continue to monitor the situation and pursue solutions to this critical problem. With more than $89,000 remaining in the Research Fund, other items can be considered such as financial support for countersuits; more thorough research on the impact of contingency fees; development of additional public opinion surveys; development of educational programs for physicians and other medical personnel, especially institutional, to make them aware of the fact that in the area of liability, prevention indeed beats a cure.

Imagination can create many areas to be investigated, but it cannot match the items that are at hand in the study of possible solutions to the professional liability crisis.

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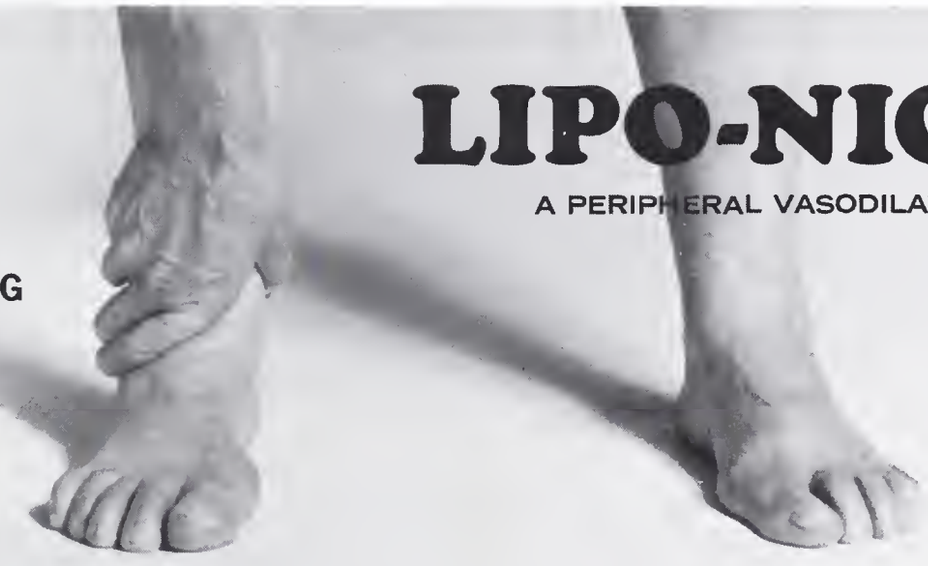
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These informal seminars, held in collaboration with the Ambulatory Pediatric Association, provide critical presentations and discussions of common pediatric problems. These seminars have so far dealt with *Urinary Tract Infections in Childhood, Obesity in Pediatric Practice, Common Orthopedic Conditions in Childhood, Upper Respiratory Conditions in Childhood, Hypersensitivity Problems in Pediatric Practice* and *Emergency Problems in Pediatrics: The Critical First Hours.*

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241/B1

Ohio Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

Periodic Programs

OB/GYN GRAND ROUNDS: Every Tuesday, 10 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Fawzy Mansour, M.D., Ob/Gyn Dept., Good Samaritan Hospital, Cincinnati 45220, phone: 513/872-2421.

ORTHOPAEDIC CONFERENCES (pediatric and adult cases— alternate weeks): Every Thursday, 7:30 AM; Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education Office, Good Samaritan Hospital; 1 credit hour; contact: Nicholas Giannestras, M.D., Orthopaedic Center, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2721.

PEDIATRIC DEPARTMENT MEETING: 2nd Thursday, each month, 9 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Donald J. Frank, M.D., c/o Medical Education Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220; phone: 513/872-2421.

PEDIATRIC GRAND ROUNDS: Every Wednesday, 8:30 AM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Donald J. Frank, M.D., c/o Medical Education, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

PSYCHIATRY DEPARTMENT MEETING: 4th Monday, each month, 11 AM and 7 PM (alternate basis); Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education Office, Good Samaritan Hospital; 1 credit hour; contact: Robert McDevitt, M.D., c/o Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2692.

SURGICAL GRAND ROUNDS— SURGICAL DEPARTMENT MEETING: Every Saturday, 8:30 AM (2nd Saturday only Department meeting is held); Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education Office, Good Samaritan Hospital; 1 credit hour; contact: John Cranley, M.D., c/o Medical Education Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

SURGICAL SERVICE MEETING I AND II: Every Saturday, 7:15 AM; Good Samaritan Hospital, Cincinnati; sponsor: Continuing Medical Education Office, Good Samaritan Hospital; 1 credit hour; contact: John Cranley, M.D., c/o Medical Education Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2421.

Single Course Offerings

May 1977

CLINICAL ALLERGY AND IMMUNOLOGY AS APPLIED TO THE PRACTICE OF MEDICINE: May 21 and 22; Stouffer's Dayton Plaza Hotel; sponsor: Wright State University School of Medicine, Departments of Pediatrics and Family Practice; cosponsor: Ohio Valley Allergy Society; 7 credit hours; fee: $35; Students, Residents, Interns— no fee/no food service; contact: Arlene Polster, Program Coordinator, Department of Postgraduate Medicine, WSU School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/429-3200, ext. 376.

June 1977

DOCTORS' GRAND ROUNDS: June 9; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Mr. Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

CURRENT MANAGEMENT OF OCULAR EXTERNAL AND INFECTIOUS DISEASE: June 9-10; Bunts Auditorium, Cleveland Clinic Educational Foundation; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $150 ($50-residents); contact: Penn G. Skillern, M.D., Center for Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

MICRONEUROSURGERY SYMPOSIUM: June 9-11; Cincinnati Convention Center; sponsor: Departments of Neurosurgery, Christ and Good Samaritan Hospitals; 25 credit hours; fee: $250 physicians, $150 residents (when accompanied by an endorsement from program director) and nurses; contact Stewart B. Dunsker, M.D., or John Tew, Jr., M.D., 506 Oak Street, Cincinnati 45219.

July 1977

NUCLEAR MEDICINE FOR PHYSICIANS: May 9-13; July 11-15; November 14-18; Nuclear Medicine Institute, Cleveland; sponsor: Nuclear Medicine Institute; cosponsor: Hillcrest Hospital; 40 credit hours; fee: $500 ($200— residents); contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370 or 371.

OHIO VALLEY SOCIETY FOR PLASTIC AND RECONSTRUCTIVE SURGERY: July 19-22; The Inn at the Peak, Clymer, New York, sponsor: AMA; 12 credit hours; fee: $50; contact: Frank M. Tooze, M.D., 104 East 2nd Street, Erie, Pennsylvania 16507, phone: 814/455-4496.

ALCOHOLISM IN INDUSTRY: July 21; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

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The Ohio State Medical Association Obituaries

WILLIAM E. BORDEN, M.D., Winter Park, Florida; Starling Medical College, Columbus, 1903; age 98; died 1976; member OSMA and AMA.

WILLIAM F. BURGER, M.D., Sandusky; Ohio State University College of Medicine, 1928; age 73; died March 6; member OSMA and AMA.

MARY ANN GRABER, M.D., Johnstown; Ohio State University College of Medicine, 1927; age 88; died March 15; member OSMA and AMA.

HAROLD GREENBAUM, M.D., Hollywood, Florida; University of Louisville School of Medicine, Louisville, Kentucky, 1924; age 78; died March 16; member OSMA and AMA.

DONALD A. GROSS, M.D., Youngstown; Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania, 1919; age 80; died March 5.

OWEN F. HUGHES, M.D., Dayton; Case Western Reserve University School of Medicine, 1944; age 57; died March 8; member OSMA and AMA.

RUDOLF KAELBLING, M.D., Columbus; Eberhard-Karls-Universitat Tubingen, Baden-Wurttemberg, 1954; age 49; died December 12, 1976; member OSMA and AMA.

NICHOLAS MICHAEL, M.D., Columbus; Ohio State University College of Medicine, 1930; age 72; died March 11; member OSMA and AMA.

HORACE V. PARKER, M.D., Cleveland; McGill University Faculty of Medicine, Montreal, Quebec, 1950; age 53; died February 1; member OSMA and AMA.

ROY PHILLIPS, M.D., Forest Park, Illinois; University of Cincinnati College of Medicine, 1923; age 86; died November 21, 1976; member OSMA and AMA.

MANUEL B. RODRIGUEZ, M.D., Cleveland; Faculty of Medicine and Surgery, University of Santo Tomas, Manila, Philippines, 1947; age 54; died March 8; member OSMA and AMA.

JOHN JAMES SANATE, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, Missouri, 1934; age 72; died March 14; member OSMA and AMA.

FRANK J. TERNOCKY, M.D., Republic; Ohio State University College of Medicine, 1939; age 64; died March 11; member OSMA and AMA.

DALE VAN DUZEN, M.D., Sun City, Arizona; University of Michigan, Ann Arbor, Michigan, 1924; age 76; died March 8.

JOHN E. WILLIAMS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1953; age 50; died March 3.

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Universal Sauna Attn: Lewis May

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News *(continued from page 273)*

JCAH Recognizes Group Practices

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals has voted to recognize group practices holding a valid accreditation from the American Group Practice Association (AGPA). The decision to recognize AGPA-accredited group practices came at the recommendation of the Accreditation Council for Ambulatory Health Care (AC/AHC) of the Joint Commission, which now conducts a program for the development and implementation of standards and accreditation procedures for ambulatory health care settings.

The AC/AHC's accreditation program became operational in April 1976. Composed of representatives from the American Group Practice Association, the American Hospital Association, the American Medical Association, the Group Health Association of America, and the Medical Group Management Association, the Accreditation Council is now accepting applications for accreditation surveys from any group practice which meets the established survey eligibility criteria.

Group practices now holding AGPA accreditation may apply for a resurvey by the AC/AHC at any time. If a group chooses to be resurveyed prior to the expiration of its AGPA accreditation, the AC/AHC decision will take precedence over that of the AGPA.

Defensive Medicine for MDs

An AMA poll indicates three out of four American physicians are practicing "defensive medicine"—that is, ordering extra tests and procedures for patients as a protection against potential malpractice suits. Medical bills of patients are increasing as a result.

More than 90 percent of the poll respondents indicate they are more conscious today that they may later be sued for malpractice. A sizable number of the doctors say they are ordering one or two more extra tests, and some are ordering three or four more. Not only are patients paying for more tests, but three out of five physicians say they have raised their own fees in the last year because of increasing malpractice premiums.

Physicians paid an average of $1,905 for malpractice liability insurance in 1973, an amount that rose to $7,887 in 1975. Physicians' business expenses— including malpractice insurance— have been rising faster than increases in fees. From 1966 to 1974, business costs per patient rose 8.3 percent per year, while fees, according to the Consumer Price Index, went up at an average annual rate of 6.2 percent.

Project USA Needs Physicians

Project USA, the American Medical Association's program to recruit physicians for short-term service (usually two weeks) has year-round vacancies at Indian Health Service facilities and National Health Service Corps (NHSC) rural communities. Project USA physicians receive $500 a week plus round-trip air coach fare. Family housing accommodations are also provided.

Malpractice insurance coverage is furnished under the Federal Torts Claims Act for service on Indian reservations; however, the physician must provide his own malpractice insurance at a NHSC site. It is a simple procedure to extend an existing coverage to include short-term service at a NHSC location. Any expense involved in this process will be assumed by Project USA.

Physicians interested in participating in this program are requested to contact John Naughton, American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610, telephone: 312/751-6388.

Portsmouth College Receives Grant

Shawnee State General and Technical College at Portsmouth has received a contract for $20,000 from the Corporation for Health Education in Appalachia Ohio (CHEAO) to establish a Health Learning Resource Center. The funds are from the Appalachian Regional Commission. The center is one of a series contracted for in Gallipolis, Cambridge, Georgetown, Chillicothe, and Athens. Each center is to serve an area generally covering a 30-mile radius. The purpose of the program is to provide up-to-date access on health information to nurses, physicians, students in health or medical programs, counselors, and a wide variety of other professionals that deliver health services.



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RECOMMENDED DOSAGE: One tablet every 3 or 4 hours, not to exceed five times daily. Children over 6: one half adult dose.

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Classified Ads

Rates: $2.00 per line. Display classified: $4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal,*** 600 South High Street, Columbus, Ohio 43215.

FIND RURAL PEACE IN A COUNTRY PRACTICE: Fully equipped office and home available. Will introduce before leaving. Call 614/946-2351. R. W. Weiser, M.D., Jewett, Ohio 43986.

FOR SALE: Office equipment of a general practitioner. Items include: platform scales, Castlelight, Sanborn (new) and Cambridge EKG machines, Keleket x-ray, Decto baby scales and table, Burdich heat light, eye testing machine, and small instruments. Also Burroughs billing machine and standard receipt machine. Office furniture including cabinets, tables, desks, and chairs. Contact: Mrs. Vemont D. Kerns, 234 N. Scioto St., Circleville, Ohio 43113. Telephone: 614/474-2389 (days or evenings).

MEDICAL DIRECTOR— OHIO STATE INSTITUTE FOR MENTAL RETARDATION: Opening available 7/1/77 for qualified physician full or selected-time basis. Either contract or supplemental pay scales. Salary from $45,000 and negotiable. Family practice, pediatrics, internal medicine, neurology backgrounds most acceptable. Supplemental allowances negotiable. Send curriculum vitae to Box 796, c/o Ohio State Medical Journal.

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LOCUM TENENT needed in emergency room in Springfield, Ohio for July and August. Best hourly rate and option to join. Phone Dr. Bay 513/399-7828.

FOR SALE: GRANVILLE, ELEGANT COLONIAL: 5 bedrooms, 6 baths, 4 fireplaces, 3.4 acres. 30 minutes from Port Columbus, 45 minutes to University Hospital. Golf course and schools nearby. $161,000. Phone: (Residence) 614/587-0548 or (Office) 614/344-1211.

PHYSICIAN: To operate general practice clinic located between Albuquerque and Santa Fe, New Mexico. For information about Cochiti Lake or how we could assist in your relocation contact: Tom Reddy, V.P., Commercial Development, Great Western Cities, 4605 Lankershim Blvd., Suite 600, N. Hollywood, California 91602, phone: 213/985-9000.

(Classified Ads continued on page 354)

FOR SALE: Office equipment of ophthalmologist and otolaryngologist. Large, black, automatic S.M.R. chair. Thermofax copying machine. Two stainless steel E.N.T. wall cabinets with miscellaneous instruments. Stainless steel eye wall cabinet with miscellaneous instruments. Twenty stainless steel allergy syringe trays. Contact: Mrs. J. Cyril Damitz, 515 Woodside Drive, Akron, Ohio 44303. Telephone: 216/867-2324 or 376-9324.

INTERNIST with special background in medical oncology desires to locate near Dayton area. Available July 1, 1977. Reply Box 794 c/o Ohio State Medical Journal.

X-RAY MACHINE FOR SALE: Fischer controls. Keleket table. 100 MA unit. Darkroom accessories included. Contact: M. C. Ellison, P.O. Box 367, Peebles, Ohio 45660.

OFFICE SUITE AVAILABLE: Piqua, Ohio. Orr-Flesh Building, center-city location. Completely furnished, including all necessary equipment to continue general practice. Reply Box 795, c/o Ohio State Medical Journal.

FOR SALE: Not renewing office lease. April 15, 1977. Will sell complete or separately: x-ray, EKG, diablier unimeter. Contact: Dr. Brecht, 1673 Cedar Avenue, Cincinnati, Ohio 45224, phone: 513/541-1827.

FOR SALE: Nine-room, air-conditioned, office building and parking lot with inner city, general practice in Northern Ohio. For $35,000, you can start with an established practice and no rent. Reply Box 790 c/o Ohio State Medical Journal.

THREE E. R. PHYSICIANS: Springfield, Ohio. Modern facility, complete medical backup. 48 hours per week, $60,000 per year plus paid liability insurance. Contact M. Ercan, M.D., 520 S. Broadmoor, Springfield, Ohio 45504, phone: 513/399-8704.



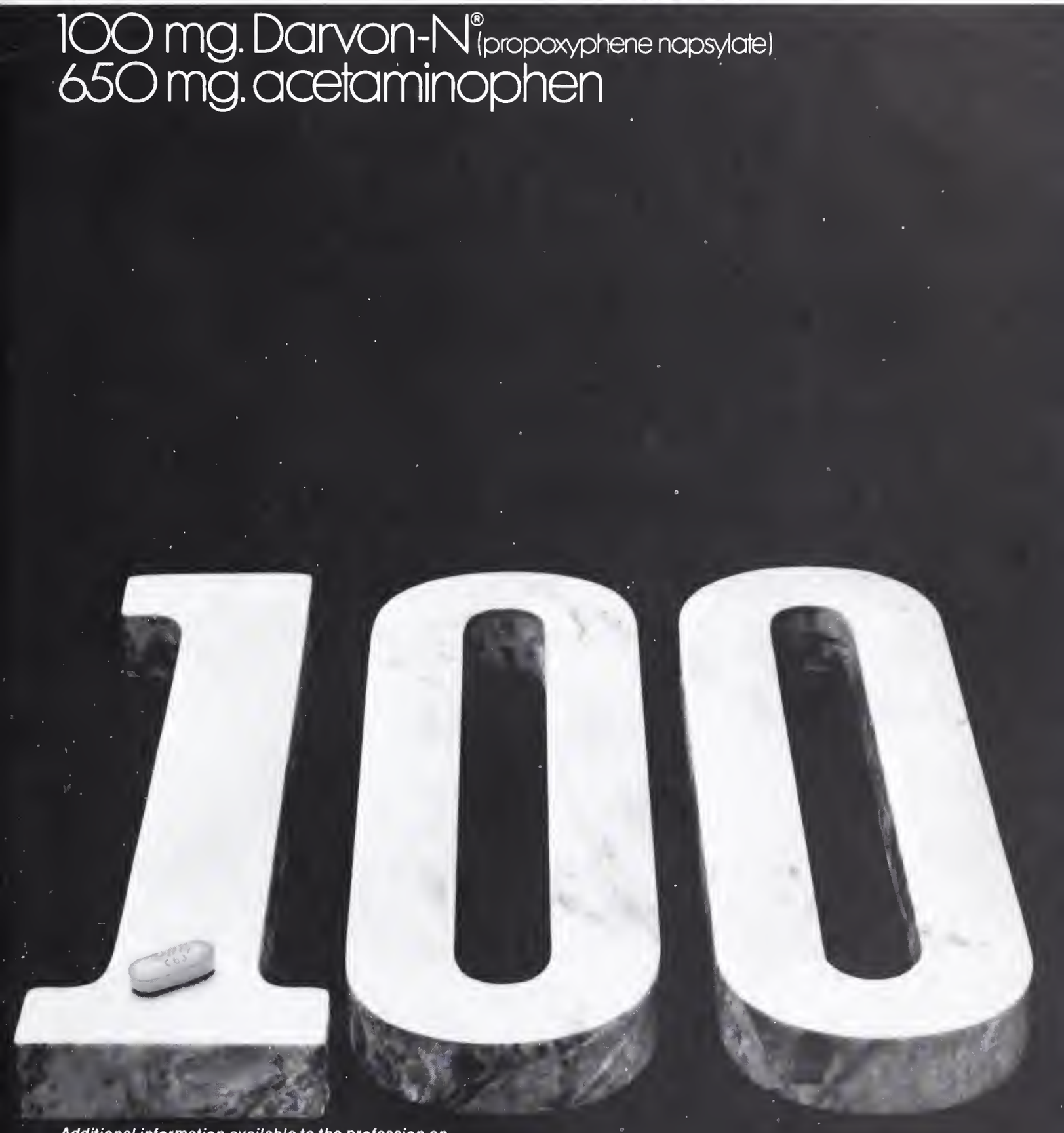
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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E.N.T.: Unexpected retirement has created immediate need for board-eligible or certified ENT physician. Excellent community, excellent hospital. Facilities and equipment available. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 389-1312.

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EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice, hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 43227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

OHIO UNIVERSITY HEALTH SERVICE seeks experienced physician to join staff of full-time physicians in a comprehensive student health service. Located in a small town in the wooded hills of southeastern Ohio. Emphasis on preventive medicine and health education programs. Applications from family practitioners and/or all areas of medical specialty are encouraged. Ohio licensing required. Salary $32,000 plus liberal benefits. E. D. Mattmiller, M.D., Director, Hudson Health Center, Athens, Ohio 45701. Telephone: 614/594-5521.

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(Classified Ads continued on page 356)

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(Editor's Note: *The Journal* presents the above classified advertisements to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.)

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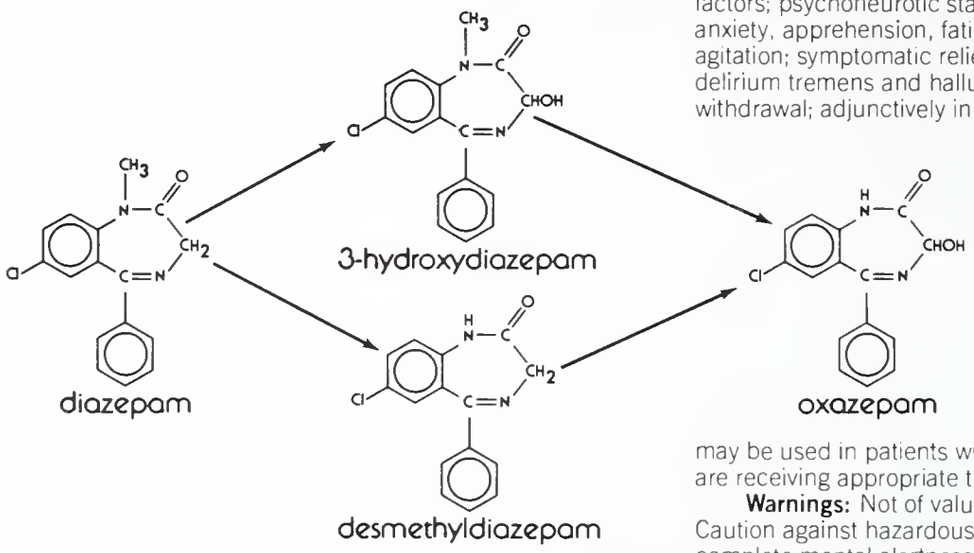
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Crowd Packs OMPAC Luncheon

A speech by political analyst Richard Scammon highlighted the Ohio Medical Political Action Committee (OMPAC) luncheon at the 1977 OSMA Annual Meeting. The large number of OSMA members and auxilians and state legislators in attendance was a good indication that OMPAC and physician involvement in the legislative arena is on the increase. Physicians and their families should join OMPAC as the first step toward involvement in political action. Your check to OMPAC, combined with your personal contact with your legislators, is an effective way to present the views of medicine and your views as a citizen.

Laetrile Bill Introduced

A bill (HB 650, Sweeney, D-Cleveland) allowing physicians to prescribe and administer laetrile in lieu of, or in addition to, accepted methods of cancer treatment was introduced and referred to the House Health-Retirement Committee. HB 650 mandates that the Director of Agriculture and the Public Health Council adopt rules governing the manufacture, distribution, and sale of laetrile in Ohio.

House Bill 650 is typical of the wave of laetrile legislation sweeping the country. The legislation requires completion of an informed consent form by the patient. The consent states that the Federal Drug Administration, AMA, American Cancer Society, and OSMA do not recognize laetrile as an approved drug or therapy. In addition, the patient acknowledges that other forms of treatment have been offered but he chooses laetrile in lieu of, or in addition to, such other treatments.

The OSMA House of Delegates at the 1977 Annual Meeting adopted a position that the OSMA continue to inform the public and legislators that laetrile is an unproven form of treatment which could be harmful to the patient by delaying conventional treatment. The House stated: "In the event that the Ohio Legislature approves the use of the drug laetrile, then it is recommended that the drug laetrile be made available to the public directly without physician's prescription if it is deemed as safe as the usual non-prescriptive drugs."

Hearings for Optometric Bill

The Senate Education and Health Committee has begun hearings on Senate Bill 163 (Jackson, D-Cleveland), permitting optometrists to use diagnostic drugs and expanding the definition of optometry. The OSMA strongly opposes the legislation. (See April 1977 issue of *The Journal,* page 187.) The OSMA Department of State Legislation has been informed that optometrists are circulating petitions within the medical community that support their proposals. Physicians should contact their ophthalmology colleagues to get all the facts prior to signing one of these petitions.

Below is a list of the members of the Senate Education and Health Committee. OSMA members are encouraged to contact these senators and other legislators to express their views on S.B. 163. Any physician who wishes to testify on S.B. 163 should notify the OSMA Department of State Legislation immediately.

Education and Health Committee Members: Chairman Morris Jackson (D), Cleveland; Vice-Chairman Marcus Roberto (D), Ravenna; Anthony Celebrezze (D), Cleveland; Oakley Collins (R), Ironton; Ben Gaeth (R), Defiance; John Mahoney (D), Springfield; Kinsey Milleson (D), Freeport; Sam Speck (R), New Concord; and Neal Zimmers (D), Dayton. (See January 1977 issue of *The Journal,* page 51, for complete addresses.)

Health Finance and Planning Bill

The House Finance and Appropriations Committee held two hearings before the full committee on HB 490 (Christman, D-Englewood) before sending the measure to a subcommittee. Members of the subcommittee hearing the bill to create a Department of Health Finance and Planning for the State of Ohio are Rep. Larry Christman (D-Englewood), Rep. James Rankin (D-Cincinnati), and Rep. Scribner Fauver (R-Elyria). The proposed legislation moves health planning from the Department of Health, which is the designated state agency under the National Planning and Resources Act, and places all planning activities under the new department. The 85-page bill transfers many other programs, including the Medicaid program, from the Department of Public Welfare to the new department. The new agency will also review and comment upon all health matters that come before the Department of Insurance, including Blue Cross rate filings. The proposed reorganization is intended to encourage comprehensive review of the health planning and financing areas, allowing the state to better administer its increasing responsibilities in the health care field.

Generic Substitution Hearings

Senate Bill 45 (Freeman, D-Canton), legislation to repeal Ohio's anti-substitution law, has begun receiving hearings in the House Judiciary Committee after its passage in the Senate last month. The OSMA Department of State Legislation recognizes that some form of generic substitution legislation will pass the general assembly this year. The Senate, through amendments to SB 45, resolved most of the medical issues in the legislation but two major issues remain unresolved.

The first issue deals with physician control of drug therapy. As SB 45 now stands, a physician can prohibit a substitution by a pharmacist by writing on the prescription "**Dispense As Written**" or "**D.A.W.**" The second issue is physician liability when a drug selected by the doctor is substituted by another selected by the pharmacist. OSMA will be proposing amendment language to address both physician control of drug therapy and liability. Any physician wishing to testify before the Judiciary Committee on SB 45 should contact the Department.



the federal scene

(Courtesy the OSMA Department of Federal Legislation)

OSMA President Recommends Council of Physicians to Advise Committee on Ways and Means

A council of privately practicing physicians to advise the U.S. House of Representatives Committee on Ways and Means in regard to Medicare and Medicaid matters was recommended by OSMA President George N. Bates, M.D., on May 6, 1977.

In a letter to the Chairman of the Health Subcommittee of the Ways and Means Committee, Dr. Bates also called for enactment of the American Medical Association's amendments to the Professional Services Review Organization statutes, H.R. 4510, and for Congress to ban the publication of names of physicians paid $100,000 a year or more for Medicare or Medicaid services.

The following is the complete text of Dr. Bates' recommendations:

The Ohio State Medical Association is pleased to submit for the record this statement in conjunction with the current task force study of health care services under the Medicare program.

We note with interest and pleasure your statement in the Subcommittee's April 19 press release that, "It is the view of Chairman Rostenkowski that it is also important to obtain the views of a representative group of individual beneficiaries and health care providers regarding the Medicare program and changes that may be needed in the Medicare law."

We also note with interest the participation of Congressman Charles A. Vanik and Congressman Willis D. Gradison, Jr., both of Ohio, as members of your task force.

The Ohio State Medical Association is pleased to offer these constructive recommendations to encourage the efficient delivery of professional services under optimum medical conditions in the best interests of the Medicare patient and to encourage maximum participation in the program by physicians and the other eligible providers of services.

It is our belief that these recommendations also would help to assure optimum expenditure of the federal tax dollar expended as a part of the Medicare program.

First, we urge immediate consideration of H.R. 4510, a bill to amend Part B of Title XI of the Social Security Act to provide a more effective administration of Professional Standards Review of health care services, to expand Professional Standards Review Organization activity to include review of services performed by or in federally operated health care institutions, and to protect the confidentiality of medical records.

This legislation has been referred jointly to the Committees on Ways and Means and on Interstate and Foreign Commerce. It has the considered support of the medical profession and is based on serious professional evaluation of the performance, missions and operation of PSRO's.

An added and highly significant benefit would be to extend this review, which is established by the Congress to enhance effective, efficient and economical delivery of quality health services, to the federal health care institutions.

But these amendments also would significantly enhance the PSRO function as an evaluator of the medical services provided hospitalized Medicare patients.

The legislation adds necessary protection to the confidentiality of PSRO records. Protecting the confidentiality of patient records in this computerized society is an enormous problem, not only in the Medicare sector of health care but in other sectors as well.

H.R. 4510 offers 25 constructive amendments to the PSRO program that would contribute significantly to achieving those goals stated in the announcement of the current hearings.

Another critically important change essential to the Medicare program is to discontinue at once the nefarious publishing of names of physicians paid over and above an arbitrary sum in one year for services to Medicare and Medicaid patients.

An example is the disgraceful release March 14 by HEW Secretary Califano of a list of physicians and laboratories paid $100,000 or more in one year by Medicare.

Of the 409 physicians listed by HEW as individual practitioners, the American Medical Association checked 166 and found a 65.7 percent rate of error on the part of HEW.

As Congressman Clarence Miller of Ohio noted in the *Congressional Record* April 20, in discussing this fiasco, "The results were disgraceful. The physicians victimized by published misinformation have reported harassment by angry patients, crank telephone calls, threats, verbal assault by angry colleagues, criticism by employees, threatened losses to their hospitals of philanthropic support, continuing embarrassment within their communities and, in one case, the possibility of sharp cuts in appropriations by the State legislature."

E. W. Peters, M.D., of Cleveland, Ohio, was listed by HEW as receiving $882,458 in 1975. Dr. Peters, one of five founders of the Euclid Clinic, retired from practice in November of 1968. He had no idea how HEW got his name, or arrived at such a huge amount of payments, nor did the Euclid Clinic.

One man in the gastroenterology department of the Cleveland Clinic was listed as receiving $2,338,434 during 1975. This left the Clinic speechless. The entire eight-man department— of which the named physician was not even a full member — was not listed at all. And the total billings of the entire department for 1975 were $1,400,000, with only 20 percent of the patients covered by Medicare.

Such gross inaccuracies of publication make a mockery of medicine's willingness to cooperate with the Medicare program. It is our urgent request that Congress provide for the immediate discontinuance of such publications.

In a continuing spirit of cooperation with The Congress, I would respectfully request that the Committee on Ways and Means establish an advisory council on Medicare and Medicaid matters. This council would be made up entirely of privately practicing physicians engaged in the day-to-day provision of professional medical services to Titles XVIII and XIX patients. Furthermore, I would urge that the advisory council be appointed by the Chairman of the Committee on Ways and Means, with the Chairman of the Subcommittee on Health, or his designee, serving as permanent chairman of the advisory council.

In this way the committee would have the direct communication with, challenges to and input from those physicians who are actively and directly involved in caring for these patients. It is through their personal and professional experiences of private medical practice that they could offer meaningful and effective suggestions toward achieving the goals set forth in your announcement of the current task force hearings.

I believe such an advisory council — and it would indeed be only advisory — would be of benefit to the Medicare and Medicaid programs, of great and significant value to the Committee and to your Subcommittee, and, finally and most importantly, would benefit significantly the persons whose best interests your Subcommittee and the member of this Association both seek to serve — Medicare and Medicaid patients.

I would welcome an opportunity to discuss the proposal with you and your Subcommittee in further detail.

Thank you for your kind and courteous attention.

It is our hope that this statement may be made a part of the official record of the current hearings.

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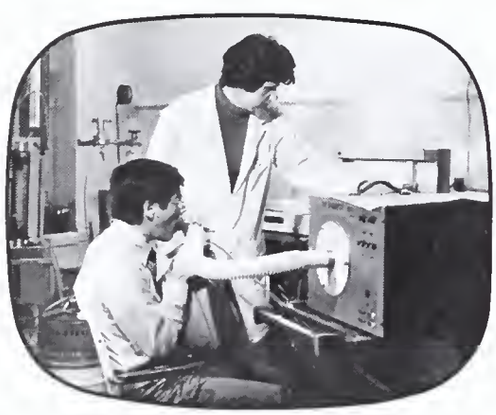
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The Ohio State Medical Association Obituaries

CARL M. BASNETT, M.D., Columbus; Temple University School of Medicine, Philadelphia, Pennsylvania, 1925; age 74; died March 25; member OSMA and AMA.

WALTER CUNNINGHAM, M.D., Marietta; Case Western Reserve University School of Medicine, 1930; age 74; died April 13; member OSMA and AMA.

CARL A. GUSTAFSON, M.D., Youngstown; Rush Medical College, Chicago, Illinois, 1934; age 82; died April 12; member OSMA and AMA.

Born in Illinois, Dr. Gustafson made up his mind during his college years to become a physician. However, he lacked the financial resources for his education and went to Youngstown to teach science and mathematics on the high-school level. Later he entered Rush Medical College, Chicago, Illinois, where he earned his medical degree. Dr. Gustafson was a Youngstown Hospital Association intern and resident before entering private practice in Youngstown in 1935. Specializing in cardiology and geriatrics, he became a member of the medical staff at the Youngstown Hospital Association and served as president of the Mahoning County Medical Society. The OSMA awarded Dr. Gustafson a plaque in recognition of his faithful service as Sixth District Councilor of the Association. In addition to his memberships in the OSMA and the AMA, Dr. Gustafson was a member of the American Academy of General Practice. He is survived by his wife, Eda, a stepson, and two grandchildren.

ROBERT H. HERMANN, M.D., New Richmond; Eclectic Medical College, Cincinnati, 1922; age 78; died April 16; member OSMA.

WALTER A. JOHNSON, M.D., Rossford; Temple University School of Medicine, Philadelphia, Pennsylvania, 1933; age 70; died April 16; member OSMA and AMA.

STEVEN KOVACS, M.D., Cleveland; Orvosi Fakultas Tudomanyegyetem, Debrecen, Hungary, 1948; age 52; died March 24; member OSMA and AMA.

DAVID KUSHNIR, M.D., Dayton; Univ. Leipzig Med. Fakultat, Saxony, Germany, 1925; age 86; died March; member OSMA and AMA.

JAMES T. LEDMAN, M.D., Cleveland; Case Western Reserve University School of Medicine, 1926; age 76; died March 24; member OSMA and AMA.

LEE PHILIP LONGLEY, M.D., Cleveland; University of Wisconsin Medical School, Madison, Wisconsin, 1937; age 65; died March 31; member OSMA and AMA.

WILLIAM F. MILLHON, M.D., Columbus; Ohio State University College of Medicine, 1915; age 93; died February 25; member OSMA and AMA.

CARL W. ROTH, M.D., Columbus; Ohio State University College of Medicine, 1940; age 62; died April 8; member OSMA.

WILLIAM N. TAYLOR, M.D., Columbus; Ohio State University College of Medicine, 1915; age 87; died September 9, 1976; member OSMA and AMA.

DONALD R. THOMAS, D.O., Delaware; Kirksville College of Osteopathic Medicine, 1951; age 54; died April 2; member OSMA.



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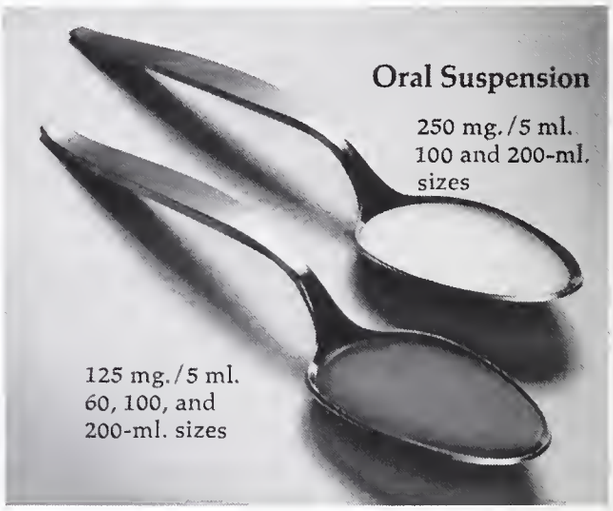
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Medical Director

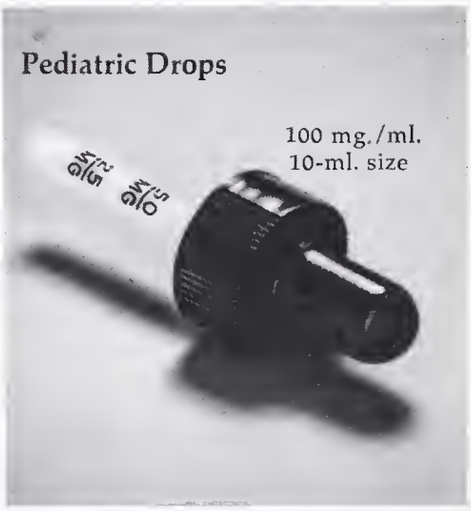
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Regional Pediatric Pulmonary Centers in Ohio

Raymond Buganski, M.D.

Acute and chronic respiratory disorders play a large role in the practitioner's daily care of infants, children, and adolescents. To assist with the more sophisticated problems in these diseases, the Ohio Committee on Pulmonary Standards has established pediatric pulmonary care centers distributed over the State of Ohio. Referral to these centers may be requested by the practicing physician. To illustrate the validity of this concept, this article reviews the care given to patients with cystic fibrosis (CF), the improved prognosis for this disease entity, and the advantages of expertise and of centralized care.

ACUTE AND CHRONIC respiratory disorders play a large role in the practicing physician's daily care of infants, children, and adolescents. The spectrum of problems ranges from the common "stuffy nose syndrome of infancy" to many diseases requiring intensive treatment for many years. The former are handled well in the everyday office practice; the latter may present a dilemma in care because of their complexity.

It has been said that the study of chronic respiratory disease in children has lagged behind that in other pediatric subspecialties during recent years; yet 30 years ago, the problems confronting the physician barely resembled the ones prevailing today.

The variety of respiratory diseases emphasizes the need for extensive education and training for those individuals concerned with the treatment of these diseases.

A partial listing of chronic respiratory diseases, as discussed by Kendig,[1] deserves some discussion. Important among these are: bronchial asthma, the single chronic disease resulting in the highest percentage of days lost from school; cystic fibrosis, a severe disease involving the exocrine glands, in which early diagnosis is necessary to prevent early death; atelectasis, the result of many causes the most important of which perhaps is endogenous, intrabronchial obstruction; bronchiectasis, a product of obstruction and injection; tuberculosis, a forgotten disease too often considered "nearly conquered"; disseminated histoplasmosis, the spectrum of disease caused by unclassified mycobacterium; neurologic disorders, such as Gullain-Barré syndrome, dystrophies, and cerebral palsy, whose end result frequently is respiratory failure; and such rarer disorders as chronic granulomatous disease or alpha trypsin deficiency.

With this difficulty of diagnosis, treatment, and overall management in mind, the Ohio Committee on Pulmonary Disease, in 1973, under the leadership of Elizabeth Alpin, M.D., Chief of the Bureau of Crippled Children's Services, designated the establishment of pediatric pulmonary care centers scattered over the State of Ohio. These centers are now in operation under the guidance of Marian Rejent, M.D., the present Chief of the Bureau of Crippled Children's Services. The areas were chosen on the basis of having the necessary manpower and facilities needed to handle the variety of respiratory diseases. At present, any physician in Ohio may refer patients to these pulmonary centers by contacting the directors by mail or phone. (See list of the centers at the end of this article.) The Bureau of Crippled Children's Services will pay for the initial diagnostic visit. The patient is seen on an outpatient basis, and further management is prescribed after suitable workup. Many of the problems may require hospitalization, but in others, a suitable plan of home therapy can be outlined and the patient returned to the referring physician.

These centers are limited in number because they require an expertise that the average hospital and clinic cannot provide. Foremost among these is the presence of a hospital-based, full-time, pediatrician specializing in pulmonary diseases, who can fully supervise the outpa-

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Submitted November 26, 1976.

tient and inpatient problems. At present, there only a few of these physicians available. The ability to provide necessary services, such as 24-hour-around-the-clock, respiratory and physical therapy with full laboratory backing, is beyond the scope of the average hospital. Also, the complex and costly equipment required for a first-rate, pulmonary function laboratory and a full-time radiologist skilled in pediatric respiratory diseases, makes the necessity of designated centers very obvious.

Cystic Fibrosis

The "center" theory of management is not a new idea; it already has been implemented in the care of patients with heart disease, especially those with congenital defects. All of the respiratory centers listed here have been involved for many years in the care of patients with cystic fibrosis. This disease entity warrants further consideration herein to show how intense care in skilled hands can markedly change the prognosis of a dread disease.

Since its identification as a disease entity in 1939,[2,3] and with more simplified methods of diagnosis, cystic fibrosis has become one of the most common chronic diseases of childhood and adolescence. At present, there are approximately 1,500 reported cases in Ohio. Much of the recognition of this disease in Ohio is due to the pioneer work of Dr. LeRoy Matthews of Rainbow Babies and Childrens Hospital in Cleveland.[4] Cystic fibrosis accounts for virtually all cases of pancreatic enzyme deficiency, the majority of patients with chronic (nontuberculous) pulmonary disease, and many children with cirrhosis, portal hypertension, and cor pulmonale.

CF is a generalized disease involving all of the exocrine glands of the body. While presenting in many ways, it should be considered primarily as a serious pulmonary disorder since 90 percent of the mortality and morbidity is associated with the respiratory tract. Intestinal-tract involvement, with many bulky, malformed, greasy, maloderous stools, is frequently encountered. In certain instances, only one of these systems will manifest signs and symptoms. In 1953, an increased concentration of sodium and chloride in the sweat was discovered.[5] This discovery has provided a valuable tool for diagnosing the disease.

Pediatric Pulmonary Centers in Ohio

Name and Location	Physician Staff
Rainbow Babies and Childrens Hospital 2103 Adelbert Road Cleveland, Ohio 44106 216/791-7300	Dr. Carl Doershuk Dr. LeRoy Matthews Dr. Robert Stern Dr. Thomas Boat
Childrens Hospital of Cincinnati Elland and Bethesda Avenue Cincinnati, Ohio 45229 513/559-2400 and 513/872-4216	Dr. Frank Kellog Dr. Robert Ingberg
The Childrens Hospital of Akron Buchtel Avenue at Bowery Street Akron, Ohio 44308	Dr. Robert Stone Dr. Francois Seguin Dr. Leora Traynor Dr. Lewis Walker
Northwest Ohio Cystic Fibrosis Center c/o Toledo Hospital 2142 North Cove Boulevard Toledo, Ohio 43606 419/473-3241	Dr. Pierre Vauthy Dr. Raymond Buganski Dr. Frederic Henry
Columbus Childrens Hospital 561 South 17th Street Columbus, Ohio 43205 614/253-8841	Dr. Gordon Young
Frederick C. Smith Clinic* 1040 Delaware Avenue Marion, Ohio 43302 614/382-8251	Dr. Edward Charnock*
Childrens Medical 1735 Chapel Street Dayton, Ohio 45404 513/461-4790	Dr. Martha Franz Dr. Robert Lutz

*Satellite Center for Columbus

Signs and Symptoms

CF is considered to be genetically transmitted as a mendelian recessive trait. It has a frequency of approximately 1 out of 1,500 live births in the Caucasian race, less frequent in the Negro, and rare in the Asian race. Three to 6 percent of the general population are heterozygotes (carriers) of this disease. Much research has been done into the actual specific etiology, but no definite abnormality has been established at this time. The clinical manifestations are produced by an unidentified abnormality of mucus secretions which results in obstruction of the bronchi, bronchioles, salivary glands and ducts, pancreatic ducts, bile calculi, intestinal glands, and seminiferous tubules.

Bowel obstruction, including meconium ileus seen in the newborn with 10 to 15 percent of CF patients, is the earliest manifestation of this disease. The signs and symptoms are similar to those of any intestinal obstruction, however, an x-ray diagnosis featuring multiple loops, fluid levels, an irregular soap mottling, and a ground-glass appearance usually can be made. After the newborn period, most of the gastrointestinal manifestations are due to pancreatic insufficiency. Most infants demonstrate a good appetite, but unless fed on demand, they eventually will have inadequate weight gain and malnutrition. Typically, the abdomen is protuberant and three to ten bulky, foul-smelling, loose, and pale stools are passed daily. Oil or undigested food may be passed. Approximately 10 to 15 percent of CF patients do not exhibit intestinal symptoms. Though deficient, fat-soluable vitamins A, D, and E usually do not cause symptoms, however, a decreased vitamin K level may manifest in early infancy. Other unusual gastrointestinal manifestations that might suggest this disease are rectal prolapse, nutritional edema secondary to hypoalbuminemia, and

biliary cirrhosis; with fibrotic replacement of the islets of Langerhans, diabetes can be seen as a sequel.

The earliest pulmonary signs may be very insidious with persistent, dry, hacking cough being the only finding. Progressive pulmonary involvement usually is seen before the second year of life with wheezing, frequent infection, increased respiratory rate, and decreased exercise tolerance. The primary obstruction of thick mucus with subsequent bacterial invasion by *Staphylococcus aureus, Pseudomonus,* or other gram negative organisms, leads to permanent lung distruction. This can be demonstrated clinically by x-ray films and by pulmonary function tests.[6]

Diagnosis

The diagnosis of CF is based primarily on the elevated sweat chloride test. The most widely used method is the pilocarpine iontophoresis method described by Gibson and Cooke.[7] Other direct-reading, chloride electrode methods have proved less reliable. Multiple determinations of sweat for sodium and chloride must be made before the diagnosis is made. A single determination is never adequate to support the diagnosis of this serious disease. Readings above 60 mEq/liter in children and adolescents are necessary to diagnose this disease; in the adult, values above 70 to 80 mEq/liter are abnormal. Due to immaturity of the sweat glands in the newborn, enough sweat for a definite diagnosis may not accrue before 4 to 6 weeks of age. This is an excellent test, but it must be performed in a laboratory whose personnel has a high degree of familiarity with the method and is involved in performing it frequently.

Other tests used in establishing the diagnosis include the BM-meconium test,[8] a method involving a test strip that changes color to ink-blue in the presence of an increased albumin content in the meconium of the newborn. Also, since most of these patients have pancreatic destruction, the levels of trypsin and chymotrypsin are reduced in the stools and can be evaluated by duodenal intubation. A vitamin-A absorption test also may be abnormal. None of these tests alone is diagnostic of CF but must be evaluated along with the family history, clinical symptoms, and other laboratory data.

Treatment

Since the exact etiologic mechanism is unknown, the treatment of CF is entirely symptomatic. The digestive component is controlled by giving adequate calories with infants possibly requiring up to 200 calories per kilogram per day. Breast milk or partially predigested formulas, such as Nutramigen® and Pregestimil,® are used in place of the usual milk formulas. Feedings normally used for the child without CF would not have suitable composition of available protein and fat. Therefore, feedings of whole cow's milk or evaporated milk, simulated breast milk feedings (Enfamil® or Similac®), or soybean formulas should not be used. The latter also can produce a hypoproteinemic state with clinical edema. Solid foods are added in the early months, usually earlier than for the non-CF child. Fruits and vegetables which are tolerated, lean meat, egg yolk, and whole egg are used initially. Though excessively fatty foods are avoided, the essential fatty acids must not be excluded.

In fact, one of the experimental modes of therapy being investigated at present is administering an intravenous, fatty-acid emulsion containing mostly linoleic acid.[9] Supplements of vitamins A, D, E, and K are given in water-miscible form. Commercial pancreatic enzymes from animal sources are used to supply the missing pancreatic secretions. These are available in capsule and powder form. The amount of the products used per meal is titrated by the effect on the stools. Salt intake must be encouraged, especially during warm weather, fever episodes, exercise periods, and excessive perspiration.

Management of the pulmonary involvement includes inhalation of aerosol solutions, postural drainage, antibiotics, and in some cases, sleeping in mist tents. The primary lung problem is mucus obstruction plus secondary infection. Intermittent aerosol therapy using decongestants, bronchodilators, and mucolytic agents followed by postural drainage helps relieve the mucus plugs. Antibiotics also can be delivered in this same manner. Sleeping in mist tents, to wet and thin mucus secretions, was popularized by the Cleveland Group in 1964.[10] In continuous therapy, propylene glycol in a 10-percent-acqueous solution or ultrasonic nebulizers with 10-percent-propylene glycol, distilled water, or half-normal saline is the solution customarily used. Although there are favorable clinical studies to support such a program, a study of the fate of radioactive aerosols breathed in a mist test seriously questioned whether the small amount of fluid deposited in the lung would thin the mucus secretions and promote their removal from the airways.[11] Nevertheless, it appears that many patients seem to benefit from the mist-test therapy. In very severe cases, usually in older children, localized lobar or segmented lavage with normal saline, sodium bicarbonate, or N-acetyl cysteine may assist in removing bronchial plugs.

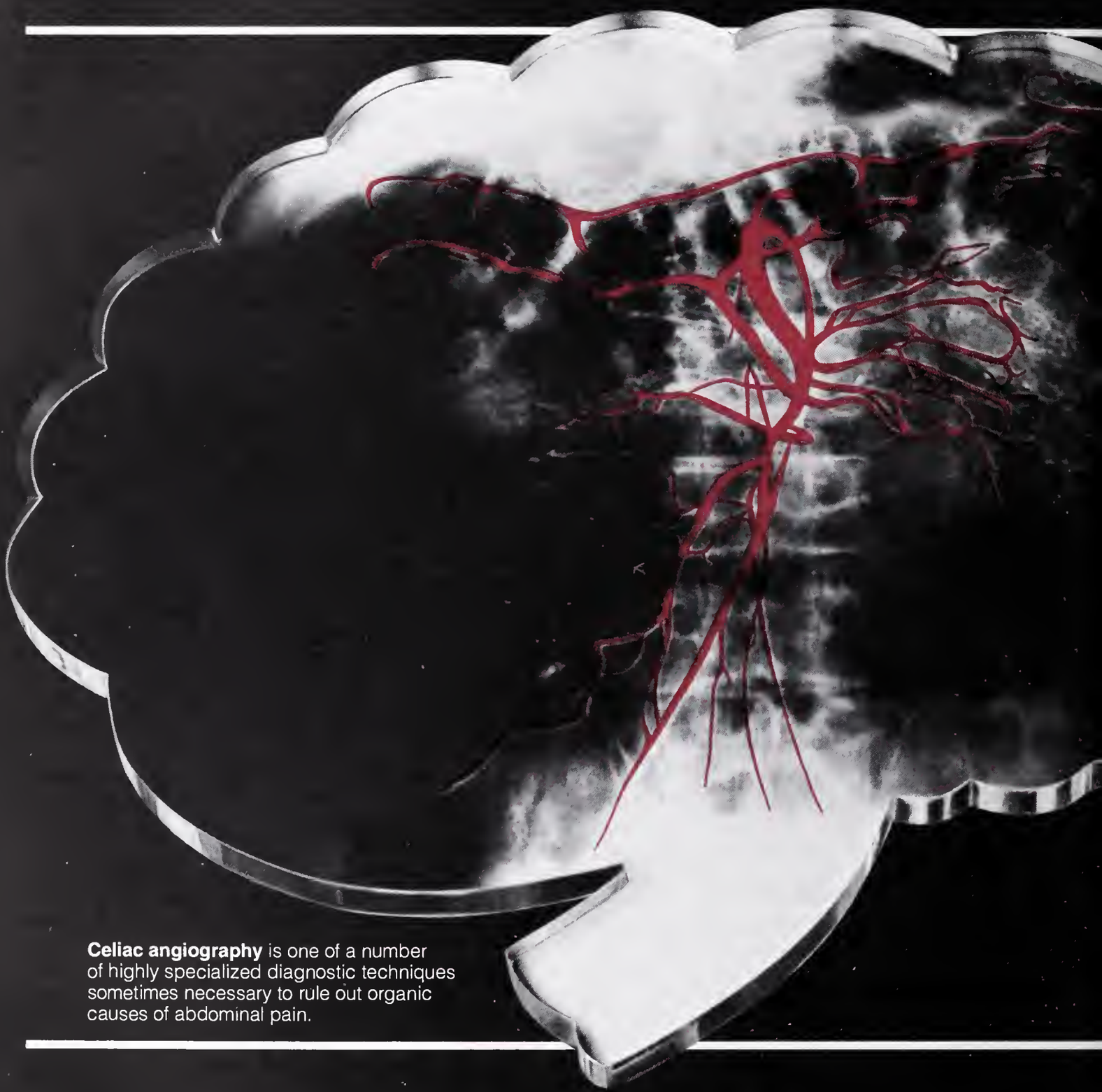
Copius pulmonary secretions form a perfect environment for bacterial colonization. Proper management of these infections forms the cornerstone of the pulmonary therapeutic program.

Activity is strongly encouraged; running and swimming as tolerated are very helpful. With increased longevity, more care obviously must be placed on psychologic needs.

The overall prognosis for CF has improved greatly with the care cited herein. When the disease was initially described, less than 3 percent of the children who had it survived five years; now, 70 percent survive to 20 years of age. The mean survival was extended to age 16 years in 1974.[12]

This improved prognosis for CF is the result of intense treatment aimed at a specific disease entity. The "center" theory of care will provide this same expertise in other chronic respiratory diseases. Most importantly,

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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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however, these centers will make this care available to all physicians and their patients in Ohio.

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Suture Technicians for Emergency Services in a Children's Hospital

James S. Clarke, M.D.
Albert R. Wills

Four former military corpsmen were trained locally to perform suturing of superficial lacerations in the emergency room of a children's hospital. Curriculum and guidelines are given. All patients are evaluated by a pediatric staff member or resident — and a surgeon where indicated — before clearance is granted. Informed parent consent is obtained. Nearly 6,000 lacerations have been sutured in the 16-month survey period, and the results have been uniformly good. Medical staff and parents approve. Administrative highlights are cited. High quality service is being provided at minimum cost.

TECHNICIANS FOR SUTURING uncomplicated and selected lacerations were trained and hired to work in the emergency medicine service of Children's Hospital of Akron in November 1974. A review of their work is presented. The objectives were to: (A) reduce time demands upon the house officers; (B) delegate technical tasks to nonphysicians; (C) contain costs; (D) render high quality service; and (E) reduce waiting time.

After approval of the program by the medical staff executive committee and the board of trustees, two former U.S. Navy Hospital Corpsmen were selected. They spent two weeks in full-time training by the emergency services nursing staff and physicians and the chiefs of general surgery and plastic surgery. Curriculum included refresher training in aseptic technique, the role of the suture technician, emergency services policies, relation to the triage system, restraint of children, and wound preparation. (See Table 1.) The surgeons gave formal instruction in the use of various suture materials, needles, and dressings, the use of tape with or in lieu of sutures, types of repair used for various wounds. The first suture training was in the laboratory. The final phase of training was actually suturing wounds, in the hospital emergency area with the staff surgeon or an experienced surgical resident physically present for supervision. When the responsible surgeons were convinced of the competency of the technicians, each technician was given a certificate attesting to his training.

The following guidelines were established:

A. Each patient to be sutured must be seen first by the attending or staff physician or senior resident and the injury judged to fall under the criteria for the technician to suture.

B. Informed consent must be obtained prior to performance of suturing, ie, explanation to the responsible parent who the suture technician is, his training, the voluntary aspect of the program, and the option of having a resident physician perform the suturing. The parent must then sign the consent (Fig. 1). Telephone consent is permissible if witnessed by another member of the nursing staff of the emergency services.

C. Injuries not to be sutured by the technicians are: (1) margin of eyelids; (2) tendon or nerve injuries; and (3) complicated wounds such as those requiring drains.

D. Some injuries to be critically evaluated— often by a surgeon or surgical resident— before clearance can be granted (often judged not suitable) include:

1. Animal bites
2. Injuries involving vermilion border of lips
3. Injuries involving cartilage area of ear
4. Wrist and hand injuries, possibly involving tendons
5. Wounds near major joints
6. Wounds on soles of feet
7. Injuries to nasolabial fold
8. Wounds over 12 hours old

Between January 1 and September 30, 1975 and January 1 and July 31, 1976 (16 months), the suture technicians sutured skin lacerations for 5,764 patients. (The number of technicians was increased to four in 1975.) Figure 2 shows the monthly distribution; unfortunately, the data for the last part of 1975 are missing. Comparison of wound sites with time of year is shown in Table 2.

Follow-up is performed by the child's regular physician. The only direct follow-up is Children's Hospital of Akron Clinic patients. No reports of complications due to

Dr. Clarke, Akron, Director of Emergency Services, Children's Hospital of Akron.
Mr. Wills, Akron, Suture Technician, Children's Hospital of Akron.
Submitted November 12, 1976.

faulty technique or inadequate professional judgment have been received or observed.

Acceptance by the parents was gratifying. Refusal occurred on the average of two per month. A more frequent problem was the inability to locate a parent for permission. Our procedure is for a physician to perform the suturing if parent permission cannot be obtained specifically for the suture technician.

Acceptance by the medical and surgical staffs has been excellent. There is wide agreement that the cosmetic results are better with the suture technicians' work than that done by most nonsurgical physicians. One of the senior plastic surgeons brought his own child in one evening for a technician to suture a chin laceration!

No publicity has been sought to "advertise" the program. About one year after it was initiated, there was a write-up in the local newspaper and a short videotape was shown on television. Now that over 6,000 patients' wounds have been sutured by this group, word-of-mouth has been the best publicity; many people mention knowing about the program when a member of the nursing staff begins to explain and asks for permission to use it.

Training of the house staff in suturing has been expedited. Those first-year residents with no prior suture

Table 1. Emergency Room Orientation for Suture Technician

Instructors	Type of Instruction
Emergency Room Nurses	Policies or procedures related to technician's role
	Informed consent
	Role of suture technician
	Legality of program
	Restraint of children
	Preparation of wound and aseptic technique
	Explanation of triage system
	Suture technician's routine duties and responsibilities when not suturing
Emergency Room Physicians	Medications—maximum dose of xylocaine, avoidance of use of epinephrine, use of sedation
	Review of policy on tetanus prophylaxis (technicians may administer)
	Physician checks lacerations prior to and after suturing
	Instruction sheet for parents
	Physician (at least a second-year resident) to sign emergency room chart
	Follow-up and suture removal: Private Clinic patients
	Referral procedure (plastic, general, or orthopedic surgeon)
	Recording of examination data, treatment, and directions
Surgeon	Discussion of:
	Sizes and types of suture material and needles
	Use of "steri-strips" and butterfly bandages, tincture of benzoin, collodion, and Dermoplast®
	Bandages and dressings, topical ointments (use and misuse), stockinettes, splints, and slings
	Length of time sutures should be left in place
	Instructions to parents regarding signs of trouble
	Lacerations to avoid—eyelids, soles of feet, nasolabial fold, vermilion border of lip, very dirty or old wounds, dog bites, and lacerations with possible tendon and/or nerve injury (hand/wrist and foot/ankle)
	How to examine hand injuries
	Burns—Surgeon should see all but very minor burns, especially those involving face and hands, and all where third-degree injury is suspected.
	Practice sessions in suturing with surgeon in laboratory
	Supervision of suturing of lacerations in emergency room by staff surgeon or surgical resident*

*Permission forms not used for patients cared for in these supervised sessions. Surgeon is in room during entire treatment process and completes and signs all forms as if he personally sutured the laceration.

INFORMED CONSENT

SURGICAL TECHNICIAN EMERGENCY DEPARTMENT

I, AS _____ (RELATIONSHIP TO PATIENT) OF _____ (PATIENT) DO HEREBY CONSENT TO AND AUTHORIZE MR. _____ (NAME OF SURGICAL TECHNICIAN) TO ACT AS SURGICAL TECHNICIAN AND TO SUTURE THE LACERATIONS TO THE _____ (AREA OF BODY) OF THE WITHIN PATIENT

I DO UNDERSTAND THAT MR _____ HAS UNDERGONE THE FOLLOWING TRAINING TO PERFORM THE ABOVE PROCEDURE

A. HE HAS THE EQUIVALENT PAST TRAINING AND EXPERIENCE OF A MILITARY CORPSMAN

B. HE HAS UNDERGONE AN ADDITIONAL COURSE OF TRAINING IN SUTURING CONDUCTED BY THE SURGICAL STAFF OF THIS HOSPITAL AND HAS SUCCESSFULLY COMPLETED THAT TRAINING.

IT IS UNDERSTOOD THAT THE SERVICES OF MR. _____ SHALL BE PERFORMED UNDER THE DIRECT SUPERVISION OF DR _____ WHO ASSUMES FULL RESPONSIBILITY FOR THE ACTIONS OF THE SURGICAL TECHNICIAN

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT MY SIGNATURE IS MY FREE AND VOLUNTARY ACT

SIGNATURE _____

WITNESS _____

TIME _____

DATE _____

FIG. 1. Consent form signed prior to performance of suturing.

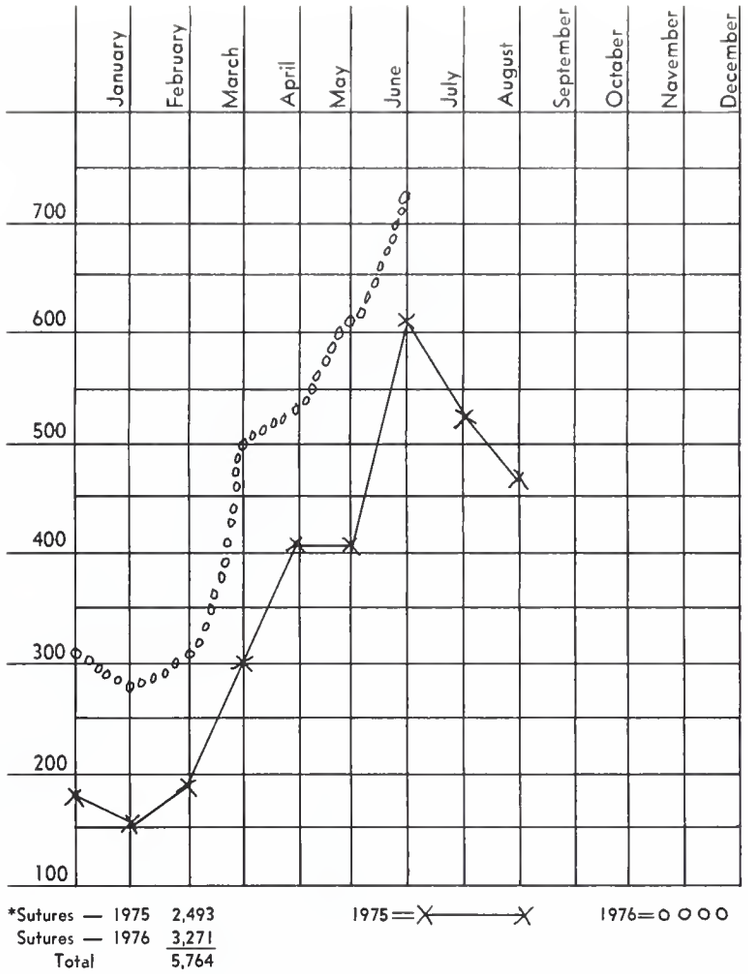


FIG. 2. Monthly record of sutures performed by technicians in 16-month period (January 1-September 30, 1975 and January 1-July 31, 1976.)*

experience have the usual didactic introduction, and a staff physician accompanies them for several sutures. It is explained to them that much of their instruction will be by the technicians as nonsurgical residents are only permitted to suture the same type wounds as the technicians.

The suture technicians work under the professional supervision of the director of emergency services, who is a pediatrician. Administratively, the technicians work for the charge nurse for ambulatory pediatric services. Their pay scale is between that for licensed practical nurses (LPNs) and registered nurses (RNs). When the technicians are not busy with suturing, they work in the emergency services as general medical technicians.

Scheduling is by demand, ie, one technician is scheduled to work 8 AM to 1 PM, two from 1 PM to 11 PM, seven days per week. Peak demand is in the hours between 4 PM and 10 PM.

Conclusion

The staff feels that the objectives have been met. A high quality service is being rendered by specially trained technicians, reducing the time demands upon the attending and house-staff physicians, maintaining professional responsibility that parents accept, and helping to contain costs.

This program is recommended to any emergency service or department where a significant number of uncomplicated lacerations of the skin occur and suitable candidates are trained to work full-time in the capacity of suture technicians.

TABLE 2. Comparison of Wound Sites with Time of Year

Wound Site	July 1975 %	January-May 1976 %
Head - face - neck	48.0	68.0
Upper extremity	24.7	22.0
Lower extremity	26.3	9.0
Trunk	5.0	0.3

(Clinical and Scientific Articles continued on page 379)

OSMA Physician Recognition Award Recipients

The following physicians have received the OSMA Physician's Recognition Award since a list of recipients was printed in the November 1976 issue of The Journal. (See page 650.) All physicians qualifying for this award have achieved 150 hours of continuing medical education during a specified three-year period.

ALLEN
Eduardo A. Guernica
Robert J. Stern

ASHLAND
William M. Emery
L. H. Martin

ASHTABULA
Marion Malinowski

ATHENS
Atmaram S. Gawande

BELMONT
Samuel Lewis
Lois R. Zimmerman

BUTLER
John H. Hanekamp
Russell Malcolm, Jr.
James R. Simpson
Robert Tennant

CLARK
J. Frederick Doyle
Kumar Mukerjee

CLINTON
Pushpa L. Makkar

COLUMBIANA
Oscar E. Budde

CRAWFORD
Johnson H. Chow
Bernard Mansfield

CUYAHOGA
Mahmoud Adam
Saul P. Baker
Charles T. Bonstelle
Charles L. Cassady
Khaled Chaouki
Demetria T. Fernandez
Stanley Lowell Fox
Garry A. Gosky
Anthony A. Greco
Thomas E. Grètter
Thomas C. Gruen
Keith R. Irish
Robert L. Katz
Richard L. King
Howard J. Klein
Adrian G. Krudy
Predrag Nastasic
Marie Pancner
Grace M. Paul
John J. Plucinsky
P. John Robechek
Juan M. Rodriguez
Frederick J. Roemer
Robert S. Rosner
Ronald J. Ross
Edward Sadar
Hermites M. Sanagustin
Harold Schwartz
Jonas Stankaitis
Ezra Steiger
Philip R. Suresky
Roy H. Thompson
Steven Y. Toth
Frits Van der Kuyp
George Vassilakis
Michael D. Zannoni

DELAWARE
J. J. Biber
Douglas L. Smith

ERIE
Euhong Kim

FAYETTE
Hugh W. Payton

FRANKLIN
Donald L. Gantt
Phillip T. Knies
Thomas H. Mallory
Paul S. Morton
William G. Pace
Arthur S. Pua
Gerald M. Penn
Hasip Temizer
James I. Tennenbaum
John W. Thomas
Thomas T. Vogel

GALLIA
Arnold J. Sattler

GEAUGA
Victor J. DeMarco
M. J. Domadia
Simon Ohanessian
Wei Tien Pien
Angelo Ramacciato

GREENE
J. R. Schauer
Akbar Vafaie

GUERNSEY
John P. Haun

HAMILTON
Bernd B. Bach
David V. Berkowitz
Stewart Dunsker
Burton W. Evans
Charles K. Ferguson
Domenico J. Foglia
Robert J. Hasl
Mark T. Hoekenga
Richard K. Lancaster
Martin B. Macht
H. Patterson Mack
Gordon M. Mindrum
Harold K. Moss
Richard B. Mulvey
Michael J. Napoliello
F. J. Niehaus, Jr.
Frank R. Noyes
Clarence J. Podore
W. Donald Ross
William J. Schrimpf
Jack D. Selzer
Wagih M. Shehata
Steven A. Spreen
John Tew
Isaac Valencia
Alfred L. Weiner
Andrew E. Weiss
Richard T. Wurzelbacher

JEFFERSON
Sadri Alavi
E. G. Macias
J. L. Mantica
Lester Stein

KNOX
Robert L. Westerheide

LAKE
Athanassios Panagopoulos

LICKING
John P. Anderson
Richard A. Moyen
Claude R. Rousseau
Julius M. Tesi

LORAIN
Henry F. Drygas
Eino Kooba
Don P. Van Dyke
Muhammad Wirk
Florencio E. Yuzon

LUCAS
Donald K. Cameron
Samuel N. Dulin
Alfred Golden
Charles H. Harrison
Bruce Janiak
Su-Pa Kang
Subhash C. Khullar
Eleuterio G. Lim
Stuart K. Remley
Edward R. Savolaine
Ronald S. Shapiro
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MADISON
J. Richard Hurt

MAHONING
Rashid Abdu
Armin V. Banez
James R. Gillis
Carl B. Klodell
Howard Kramer
Kalman C. Kunin
William D. Loeser
Herbert A. Parris
Richard J. Solyn
Walter J. Tims
Jan P. Vette

MARION
Pavanender Gupta
Antonio N. Mortera

MIAMI
Azher A. Quader
Robert L. Sutton

MONTGOMERY
Arnold Allen
Herman J. Bearzy
G. William Bretz
Oscar B. Cataldi
Delores D. DeGuzman
Robert J. Kuchlewski
Etta Leahy
W. J. Lewis
Marion V. Lingle
Henry N. Maimon
L. E. Palmer
Ramchandra Ramnath
Mahesh M. Shah
Robert P. Stafford

MUSKINGUM
Benjamin Gilliotte

PORTAGE
Rogelio G. Marcial

PUTNAM
James B. Overmier

RICHLAND
William R. Houston
Michael P. Krieger

ROSS
T. J. Albertowicz
David McKell

SANDUSKY
Robert A. Borden

SHELBY
Edward A. Link

STARK
Robert N. DiSimone
Christopher M. King
Joseph W. Kolp
Edward L. Mitchell
Marino G. Ong
Ralph A. Polumbo
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SUMMIT
Linda L. Alston
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William G. McNally
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TUSCARAWAS
Leroy L. Appel
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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
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Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

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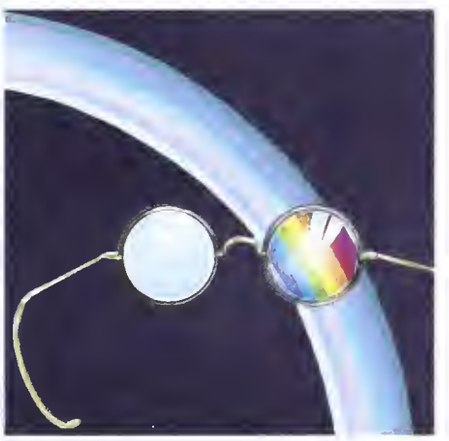
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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

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Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

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Some Additional Notes on Hospice

Mary Ann Rose, M.S.N.
Walter J. Pories, M.D.

Following a visit to three hospices in England, the authors describe the physical plant, including furnishings and the arrangement of patient units; staffing patterns for medical and nursing care and social services; patient flow through the use of "floating beds"; and the day hospital associated with one hospice.

Editor's Note: *The economics involving English "Nursing Sisters" and American "RNs," "LPNs," and Nurse Assistants must be considered when evaluating the systems of the two countries.—R.L.M*

RECENTLY, we had the pleasure of visiting England for a first-hand look at the English "hospice" approach to the care of the terminally ill. The Cancer Center, Inc. and the Cuyahoga County Hospital System, with the support of the Gund Foundation, had spent a year planning for a hospice-like facility in Cleveland. It has been named "The Serene." As these plans progressed and decisions arose around organization, staffing, and even furnishing, it became apparent that little guidance for them was to be found in hospice literature which mainly described the details of care. This article, written after our visit, presents information and impressions of the English hospice which we hope will be useful to others in development stages.

A word about these "hospices" is necessary. In essence, a hospice is a facility dedicated to the care of the terminally ill. They have existed in England for many years, essentially as nursing homes, but only recently have come into prominence through the efforts of Dr. Cecily Saunders. Dr. Saunders established St. Christopher's, a facility where pain is controlled by careful medical management, nursing care is given in a highly personalized fashion, and the patient and family are helped to live his/her last days to the fullest. Following Dr. Saunders' leadership, other hospices have developed in England and the movement is now extending to the United States.

The facilities we visited included the Michael Sobell House, a 25-bed, newly built "house" on the grounds of the Churchill Hospital in Oxford; St. Luke's Hospice, a 25-bed facility in the city of Sheffield; St. Christopher's Hospice, a 50-bed unit in London. (The latter is being expanded to 80 beds.) In addition, we visited the very progressive Cowley Road Hospital for geriatric patients headed by Dr. Lionel Cosins. We also took a long look at the supportive services for the patients outside hospitals such as a very comprehensive transportation service, outpatient clinics, and rehabilitation and social centers for the handicapped and the elderly.

The Physical Plant

The most striking initial impression upon entering each hospice was the spirit of warmth and good cheer. Instead of the hushed, somber, and rather reverent atmosphere we had anticipated, we were met by a cheerful hostess in a pleasant entryway, heard sounds of laughter, chatting, and perhaps a television. It was almost a physical relief to find we could relax, be comfortable, and chat with people who obviously were feeling good about the place. This included the patients!

The furnishings also were noteworthy. The walls invariably were painted white or paneled in light wood, and there were many windows to admit outdoor light. Green plants abounded; they were not "decorator perfect" but gave a feeling of things thriving and growing. The plants were in rooms, at bedsides, in halls, and in other locations. We also saw *many, many* chairs, and they were easily movable. Day rooms or sitting rooms tended

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Submitted October 4, 1976.

to have an assortment of chairs. For example, there were recliners for patients who wish to fall asleep in the day room, geriatric chairs (higher in the back so the patient can get out of it more easily), and regular sitting chairs. The day rooms always had a somewhat cluttered look because people were at home there and they moved things around. We particularly liked the wood-burning fireplaces we saw. However, England now has rather strict pollution control and smoke abatement acts, so fireplaces can no longer be used regularly.

All hospices had chapel facilities. St. Luke's, in Sheffield, had a large room off the entry area that served as a lovely and peaceful Christian chapel. Particularly striking about this one was that it opened very easily into the reception room area so that on big occasions, like Christmas or Easter, more patients and families could be accommodated in the reception area and still see the service. Our host at St. Christopher's, Dr. Tom West, was very critical of the chapel at his hospice because wheelchairs could not go through the door. At Michael Sobell Hospice, the large day room area had a pair of sliding doors at one end. Behind them was a simple and lovely altar for services. When the room was not being used as a chapel, the doors were closed and the room became a dining area. (At St. Christopher's, by the way, Dr. West commented that, so far, no patient had died during services. Patients can go to chapel if they desire, even if they are very ill, and the staff anticipates that this event could occur.)

The patient rooms, generally four to eight bed units, also had plenty of extra chairs and often a round pedestal table where people could sit to eat, play cards, or visit. Again, the rooms were pleasant and homey. This effect was enhanced by the fact that there was a hand-knit or crocheted afghan on every bed. The afghans were made by neighborhood ladies, were the patchwork type, were multicolored, and each was different. Nurses reported that there was no problem washing the afghans; they gave the place a totally homey, comfortable look rather than a uniform, institutional look.

Much space was set aside for linen storage. The nurses here change and bathe a patient four to six times per day for odor control and comfort, so an ample supply of linen is necessary. Also, many pillows were needed for positioning, and storage space was a major consideration. There also were washers, dryers, and outside lines for laundry of patients' personal things, such as nightgowns, or visitors' clothing.

The Patients

Most of the patients we saw were in the older age category; although, in a staff conference we attended, there was considerable discussion about teenagers who had been patients recently. None of the hospices we visited accommodated children; there seemed to be a consensus that dying children should be cared for in an acute care facility. However, young relatives of patients were welcomed readily; and in Sheffield, a 6-year-old son whose mother was dying was sitting on the floor playing by her bed. He was about to have a birthday celebration with the staff, and they had made him a cake.

None of the patients seem obtunded due to pain medication, and all the patients we talked with appeared to be quite sociable and comfortable. We saw no patient in any hospice who appeared to be experiencing any significant pain. One patient, who was discussed in a care conference, was on a daily regimen of 90 mg of heroin which was felt to be a very high dose. She was a little "dopey," but she was dressed and walking around the ward. The staff was trying to keep her comfortable and to reduce her dosage of drugs. On the other hand, Dr. West admitted that pain control was successful in only 90 percent of the patients at St. Christopher's; 10 percent of the patients presented insoluble pain problems.

Hospice Physicians

The doctors were focal points for each hospice because of both their medical skills, and perhaps more important, because they provided inspiration and leadership. We noticed in each hospice that the physician was very involved and played a leadership role. At St. Luke's particularly, we felt that the facility presently depended upon the very strong personality of the leader, Dr. Eric Wilkes. He was so dynamic, aggressive, and self-confident that people just radiated to him. In terms of numbers, St. Christopher's had one doctor for every 12 to 15 patients; St. Luke's had two doctors for their total census of 25 patients; and Michael Sobell had one physician. No physician devoted full time to a hospice, having large practices outside, but each spent a good part of each day there and obviously regarded the hospice as a major responsibility.

Nursing Care

The nursing care was impressive and, on the whole, quite different from our acute care nursing in the United States. We cannot emphasize too strongly the unhurried, highly loving, individualized care that was given to every patient we saw. The patients were very clean, odor free, positioned well when necessary, and cheerful. Patients were cared for with a minimum of hurry, institutionalization, or regimentation. To illustrate this, we might look at the "routine" at meals, which is quite different from our own. A tureen of soup would be brought into the ward and the nurse would say to her patient: "Mrs. George, would you care for a little soup?" Yes, Mrs. George would care for a little soup today. A small amount of soup would be ladled into a bowl for her. She also would have a linen napkin and a fresh flower. Then she would eat—or be fed if necessary—a very small amount of soup. During this time, she would be urged, cajoled, and encouraged to eat; it would be a time of socialization for her with the other patients and the nurses. Once the soup course was finished, those bowls were collected and the fish or meat was brought out. Again it would be "Mrs. George, would you care for a little bit of fish?"

"Yes, perhaps a little bit." The nurses reported that the patient may have eaten only a little bit of each kind of food in the mealtime, but she would have eaten something and the mealtime would have been a pleasant social occasion. Here in the United States, if we might recall, the tray is placed in front of the patient with very large quantities of all courses already distributed on the tray. The trays are routinely picked up in a half hour or 45 minutes. A further significant difference was that sherry or beer was always served before the meals. This would stimulate the appetite and relax the patient as well as contribute to the nutritional state.

Staffing

A large staff of nurses was needed. The consensus was that the use of part-time nurses was imperative to maintain a high morale in the nursing group and to provide sufficient numbers of nurses for a rather high nurse-patient ratio. Shifts were flexible to meet the needs of the nurses. For example, one nurse might work from 8 o'clock in the morning to 2 o'clock in the afternoon, while another might work from noon until 7:30 PM. Volunteer professional nurses were used as were volunteer aides (or, as the English would call them, auxiliaries). There always was a nursery where children of the staff could be cared for during working hours.

In every case, the aides were trained by the staff of the facility itself. These were lay people with no medical background whatsoever who were given a bedside nursing course. Because of this, they were not aware of the regimentation and institutionalized approach used in acute care. In addition, the hospice would set bedside nursing standards for the patient care. Professional nurses were given a similar type of bedside nursing review. They usually were inactive nurses who took a "back-to-nursing" course offered by the hospice and then joined the staff. This is quite an unusual approach, by United States standards, but we found it at all three hospices and everyone was quite pleased with it.

Social Service

The social service personnel were highly valued; they were busy coordinating services at home, helping with financial matters and other problems. However, we felt that the counseling function of the social services perhaps was limited. For example, in a case conference which included all the staff, the nurses asked what might be done to help the 6-year-old child whose mother was dying. How could he be helped to adjust to what was going on now and to the approaching loss of his mother? The group, including the professional social worker, felt that this was a concern, but it never arrived at the idea of obtaining professional counseling for the child through social service or any other service.

Routines of Care

Some of the routines really were quite specialized. Admission to the hospice was felt to be a very warm and personal thing. The patient was met at the door with a bed that had been warmed for him. At St. Christopher's, the nurse greeted the patient by getting into the ambulance that had brought him, shaking his hand, calling him by name, and telling him they were pleased to have him. He was transferred to his bed just inside the door and taken to his ward, where he was introduced personally to each of the other patients.

The procedure at death was similarly thoughtful. At St. Christopher's, the patient was removed from his bed and that bed was left open for 24 hours. At St. Luke's, the newly deceased was taken to a room where the family could view the body. In the viewing room, a curtain could be drawn between the visitor and the body so that a person could sit in the same room with the deceased and not be forced to look directly at the body.

Analgesics were not given intermittently, but rather on a regular basis before the pain would return. We felt this was a very effective way of controlling pain as the patient lost his anxiety about how bad it should get before he "asked for something." Most medication was given orally, including heroin, morphine, meperidine, hydromorphine, codeine, and aspirin.

Supports for the Patient in the Community

The home-care support for the terminally ill patient outside the hospice is absolutely astounding, just as it is for the geriatric patient. Some of the patients living at home received as many as four visits per day by the visiting or "district" nurse. Some lived in "warden-supervised housing." In this type of housing, the patient lived in an apartment of his own. There was someone in the building, usually a young couple, paid by the Health Authority to check on each resident morning and evening to make sure that he was okay. Special pieces of equipment for maintaining independence were brought to the home by the district nurse; we had not seen some of these items in the United States. "Meals on Wheels" delivered two meals per day to the patients. In some communities, there was a night sitter program. Patients needing to come back to the hospice for outpatient visits, day hospital (to be described later), or check-ups by the doctor, were always transported by the district transportation system which did everything from the road trauma work to transporting the ambulatory patients to check-ups.

All of these services were provided for and supported by the government through the Area Health Authority. Cost to the individual patient was negligible (of course, taxes were substantial) except for a small deductible for drugs. Although we questioned if this was cost effective, we couldn't help commenting that if we were elderly or terminally ill, our lot would be better with these services available than in the United States where we have limited and sometimes fragmented services.

Day Hospitals

At St. Luke's, a "day hospital" had opened recently for the terminally ill patient who can manage at home

most of the time. We first encountered the concept of the day hospital in the Cowley Road Hospital for geriatric patients. There, ambulance service would pick up the elderly patients and bring them in to spend the day. Any nursing, chemotherapy, laboratory testing, social service, or physical therapy that was needed would be done during that day. The patients would have a fine time socializing with the others in the day hospital and would be transported back home at the end of the day. This worked quite well at Cowley Road: we saw a number of people who, at age 80 or 90 years, were quite independent at home with careful supervision through the day hospital.

The experience at St. Luke's with the day hospital, although brief, was quite favorable. Staff reported that the patients who could manage fairly well at home did come back from 9 AM to 3 PM once a week, again transported by the district transportation service. Once they arrived at the day hospital, they would be seen by the doctor, medications would be checked, inhalation therapy or physical therapy would be given as needed. (The staff felt that physical therapy was very important even when it had very short-range goals). The volunteer hairdresser probably would come in; some patients who did not have a shower at home would enjoy the shower or bath; and everybody would return home with the departure of the ambulance at 3 PM. The staff rotated to day hospital duty and, although it was only a few months old, everyone seemed to enjoy it.

Floating Beds

The floating bed concept also originated in England. One or two beds in each hospital unit are designated as "floating beds" and have a patient occupant for two or three days of the week. He would arrive on Sunday and leave on Wednesday. The next patient then would occupy the bed from Wednesday through Saturday, when he would leave. Patients were admitted regularly. This gave the family a rest, gave the health care providers a rather long period of time to observe the patient and adjust the course of treatment, and also increased the utilization of a single bed. This worked well at Cowley Road with elderly patients and, apparently, is in rather widespread use in England. The Michael Sobell hospice was planning to use one bed in this way, admitting each patient for a week. The other hospices did not use it.

St. Luke's had a rather interesting variation of the "floating bed." One bed was designated a "holiday bed," and funds to support it came from private sources—not the Health Authority. This bed was used for a patient who suffered a chronic illness and was being cared for at home. The patient would be brought to St. Luke's and stay in the "holiday bed" for two weeks while the family went on vacation. The nurses liked this arrangement because it gave them one patient who was not terminally ill; the patient liked it very much because it gave him new types of socialization and sometimes highly skilled medical care that he may have lacked. Of course, the family enjoyed it immensely.

General Impressions

Although one can argue philosophically about the pros and cons of England's system of supporting medical care, one finds it hard to deny that the terminally ill patient can avail himself of a vast array of supportive services throughout his final days. In most of our communities, we do not even approach the wide range of services needed to maintain a patient comfortably at home. It is most unusual here to find a nurse visiting a home four tmes a day as there rarely is financial support for this effort. There is no communitywide transportation service. We do have "Meals on Wheels"; however, there is no supervised housing. We conclude from this, among other things, that the length of stay in the Serene may be longer than that of the patient in England.

We anticipate a problem of instilling a warm, supportive, and absolutely unhurried philosophy in the Serene staff. We must recall that the American nurse has been trained to deal with a high volume of patients, generally about 40 acutely ill patients on a unit, and to take a mass-production approach to cope with this load. In order to have the nurses function in the highly individual and unhurried atmosphere of a Serene, we must help them "unlearn" some of the old approach. Therefore, we favor very highly the idea of sending two nurses and our administrator to Sheffield to learn firsthand the routines and the philosophy of the hospice there. We also strongly support the idea of training our own lay people as nurse's aides.

It becomes evident that before either a day hospital or a floating bed concept can be implemented here, a transportation service will have to be operating in the community.

We are grateful to the Cleveland Foundation; the Cancer Center, Inc.; and the Department of Community Health, Case Western Reserve University, for making this trip possible.

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Urinary Screening of School Children

James S. Allen. M.D.

A comprehensive screening of school children for urinary disease is presented. In a screening of over 10,000 children by use of a history questionnaire, dipstick evaluation for protein and sugar, voiding audiograph, dipstick culture, and a physical examination of the boys, a total of 22 percent of the children were found to have conditions suggestive of urinary tract difficulty. The most common conditions were abnormalities found on physical examination of the boys and positive urine cultures in both sexes.

SCREENING OF SCHOOL CHILDREN for urologic problems (urinary abnormalities) has been a rewarding experience, and multiple abnormalities have been discovered. An increased awareness of the genitourinary tract by the primary physician has resulted. The comprehensive program which we conducted from 1972 to 1975 is presented herein.

The pilot program of 1972 involved the screening of first grade students at one local grade school.[1] From this initial experience, we determined that an older child, eg, third grade (8 to 10 years of age), could be screened more easily. We also refined our urine culture techniques, improved the history questionnaire, and developed a program for postscreening follow-up. A group of 215 children were evaluated in the pilot program.

During the second year (1972-1973), the entire third grade population of the Akron Public Schools was screened, using a team of nurses and physicians.[2] A total of 3,312 children were screened in a six-week period. Further refinements in procedures included a second culture of those children who had positive cultures initially, the development of a methodology to provide a more uniform operation with less classroom disruption, and better follow-up techniques.

In our past two years of operation (1973-1974 and 1974-1975), no major changes were made. An additional 10,000 children were screened. During these two years, we used the same technician (LPN), our urology residents (who had completed their six months' rotation in pediatric urology), and better follow-up techniques. The program also was expanded to include not only the Akron Public Schools, but selected parochial schools and some county schools that had requested the screening. Individual schools were screened over a one- to three-day period, depending on the size of the school. The author interpreted all of the results before any conclusions or opinions were offered to the schools and parents. All children with positive results were referred to their private physicians and/or urologists.

Overall, the screening included the 20-response, urologic questionnaire requiring only yes/no responses, a dipstick evaluation for protein and sugar, a voiding audiograph,[3] a 24-hour, dipstick culture including an instant nitrate reading, and a physical examination of the abdomen and gentalia of the boys. Proper permits for evaluation were obtained from the parents, and a written report of the conditions (or lack of them) was sent to the parents via the school. Instructions as to follow-up by the family's private physician were included, as well as a card for the physician to return to us for evaluation of the degree of follow-up and correctness of our diagnosis.

Results

A total of 10,973 children, 5,559 boys and 5,414 girls, were screened in the 1973-to-1975 period. Of those screened, 22 percent were reported to the schools (parents) as having conditions suggestive of a urinary difficulty. The majority of those reported, 1,769 (75 percent) were boys; this was expected since they had a physical examination and the girls did not. A summary of the observations can be found in Tables 1, 2, and 3.

Table 4 represents the best follow-up data we were able to obtain on a voluntary basis and is based on the screening of 3,575 children in 1974-1975. In some cases, as will be pointed out, there was a philosophic difference

(continued on page 386)

This study was made possible by funds from the Sisler-McFawn Foundation, the Kidney Foundation of Summit County, Walsh-Jesuit High School, and the Women's Auxiliary of the Summit County Home Builders' Association.

Dr. Allen, Akron, Staff Member, Akron City, Akron Children's, and St. Thomas Hospitals, and Akron General Medical Center.

Submitted October 14, 1976.

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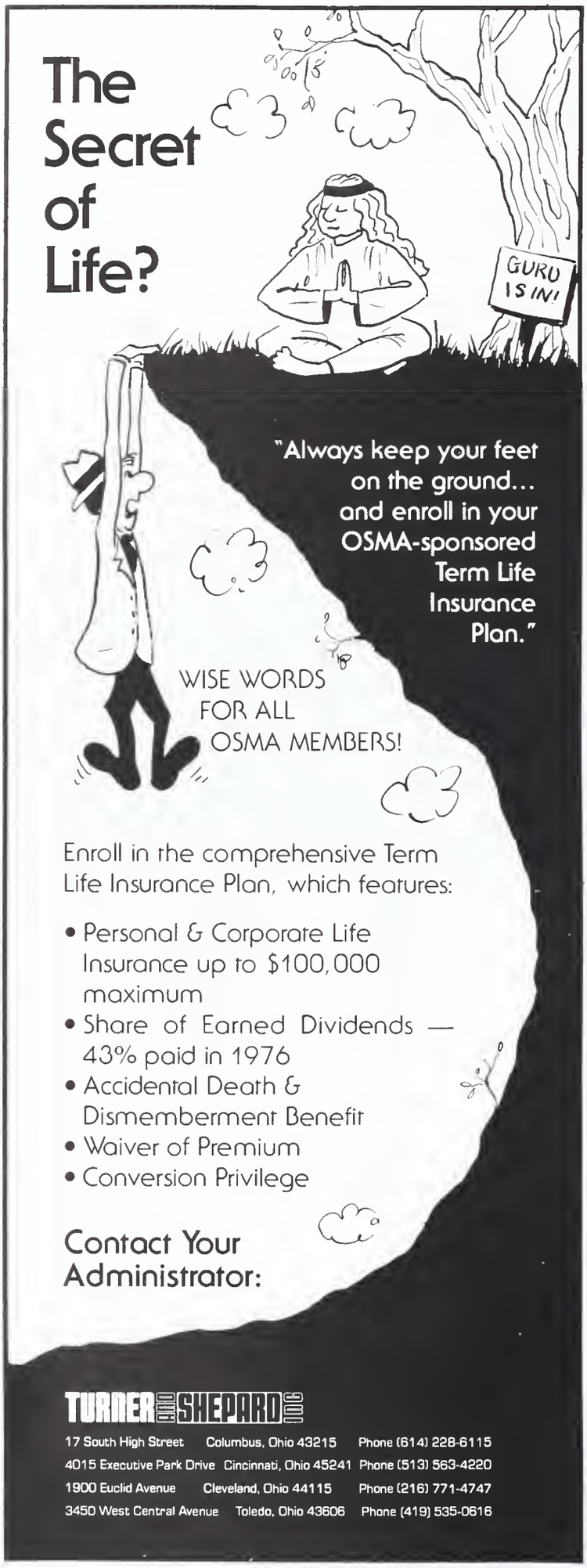


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Urinary Screening

(continued from page 384)

TABLE 1. Criteria to Determine "Positive" (Abnormal) Conditions

1. Positive culture X 2
2. 1+ protein or sugar
3. Five positive responses on history
4. Positive audiograph with three positive responses on history or trace of protein/sugar
5. Physical abnormalities in boys

TABLE 2. Positive Results in Screening

	No.	%
1. Abnormal boys' physicals	1,551	16
2. Positive cultures*	777	7
3. Positive history	331	5
4. Positive protein or sugar	139	1

*612 of the positive cultures were girls (80%)

between the urologist and the pediatrician as to the significance of entities, eg, meatal stenosis, asymptomatic bacteriuria, and enuresis.

In the entire 1973-1975 follow-up, it was determined that the interval between the screening and dissemination of the results to the family averaged four weeks with an additional six weeks elapsing before medical consultation was obtained. It was further found, in a random sampling, that a surprising 58 percent had received a course of antibiotics for other illnesses ("colds") during the eight-to-ten-week interval. We strongly suspect that this altered the number of children reported as having a positive (usually asymptomatic) urine culture but many were later reported by the private physician as having a negative culture. There has been a philosophic difference between the urologist and the pediatrician as to the significance of meatal stenosis. I know of 20 children we reported as having a "pinpoint" meatus for whom the private physician returned a follow-up card as a "disagreement" because the child was asymptomatic. As a urologist, I feel the condition *is* abnormal even though no recommendation (or advisement) as to treatment of the asymptomatic child was entertained. An area of definite error involved retractile testicles which were reported as undescended. The rapidity of the examination and changes of screening locales did not allow both prone

TABLE 3. Abnormalities Found in 1,551 Boys

Condition	No.
Meatal stenosis	1,366
Undescended testicle*	75
Phimosis	51
Hypospadias	9

*One half were found to be retractile (hydrocele/hernia).

TABLE 4. Follow-up Data for 628 (17%) of the 3,575 Students Screened 1974-1975*

Source of Data	Agreed	%	Disagreed	%
Preprinted return form	177	57	74	24
Calling physicians' offices on unreported children	31	10	10	3
Calls to 25 random patients	14	4	8	2
Total*	222	71	92	29

*314 of the 628 positives

and upright examination of the genitalia. We see no solution for this "error."

Conclusion

The screening has been a very rewarding effort; it was performed at an economical cost of $3.50 per child. These techniques can be applied to any population group with similar ease, cost, and presumable results. The educational benefit to parents and physicians has been tremendous. Each year, we are finding a lower percentage of abnormalities which can be partially attributed to our primary physicians' greater awareness of the genitalia and urinary system. Since the program was instituted three years ago and with the refinement of our techniques, public health agencies, community physicians, and others interested in preventive medicine are encouraged to undertake such a screening program.

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RADIOLOGIC SERVICES consist of general diagnostic (chest, skeletal, digestive, and urinary systems); angiography; mammography; nuclear medicine; ultrasonography; computed tomography; and radiation therapy. A review of these services will remind primary care physicians of the astronomic growth and diversification of the radiologic services available in hospitals and clinic departments, as well as radiologists' private offices.

The purpose of this discussion is to consider guidelines emphasizing numerous methods of improving patient care, indications and evaluation of certain procedures, reducing costs, and emphasizing the benefits to be gained by using the radiologist as a consultant.

With the possible exception of pathologists, primary care physicians refer more patients to radiologists than any other special group of physicians.

There is an optimum time for patients to obtain their examinations — even a routine x-ray of the chest. Departments of radiology usually are the busiest in the mornings because so many examinations require the patient to be in the fasting state (barium studies, excretory urography, and others). An appointment always is preferred as it enables clerical assistants to obtain the patient's previous reports and radiographs for comparison purposes.

Appointments are mandatory for examinations requiring longer periods of time and special preparation of patients. If there is a medical reason to deviate from the routine-type preparation, this information should be shared with the staff of the radiology department. Optimum sequence of studies of abdominal organs saves repeat examination and hospital utilization. Whereas it is physically possible to examine the urinary tract by intravenous pyelography (IVP), the colon (barium enema), gallbladder, and upper gastrointestinal tract in one day, most patients and physicians prefer at least two days for the four studies, if all are necessary. The IVP should precede any barium study; it can be conveniently combined with a barium enema examination using a single preparation of the bowel. The gallbladder and upper gastrointestinal tract are conveniently studied in one day. On the basis of signs and symptoms, it is difficult — and impossible in many instances — to distinguish between the presence of cholecystitis and peptic ulcer disease. In order to use radiologic services to the best advantage for the patient and the referring physician, it is necessary that the radiologist be familiar with pertinent medical and surgical history, as well as significant symptoms and signs. The radiologist is interested in knowing what the referring physician is looking for and what is suspected. Frequently, the radiologist will alter the procedures when such information is made available.

Although it may seem elementary, we urge referring physicians to have an understanding with their patients concerning the procedure to be followed upon completion of the x-ray examination, mainly, *when* the patient should telephone or return to see the referring physician. As soon as the examination has been completed and the films processed, they are interpreted by one of the radiologists. If the examination has been performed because of recent injury, a preliminary report is given to the emergency room or to the referring physician. Most radiologists also attempt to do this if an unusual or significant abnormality is found, in order to expedite care of the patient. If there is other reason to learn the result of an examination sooner than the routine written report, note could be made on the request. Most radiologists prefer not to show the patient his radiographs, but they will do so if requested by the referring physician.

Physicians and house officers are encouraged to review radiographs of their patients. The preferred method includes obtaining the films from the file or processing

Drs. Osmond, DeMarco, Farmer, King, Klein, and Sykora are associated with the Drs. Hill and Thomas Radiology Group, Euclid General Hospital, and the Euclid Clinic Foundation, Cleveland.
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Submitted December 29, 1976.

room with the assistance of a member of the secretarial or technical staff, followed by consultation with the radiologist. Radiographs are medical records; they should not be taken from the department except under unusual circumstances. In this way, radiographic studies are available for future use, rather than "filed" in unusual locations. When they are removed from the department of radiology, they should be "checked out" through a member of the departmental staff and officially recorded as being in the possession of the requesting physician.

Physicians usually are familiar with indications, the medical significance, limitations, and costs of most general-diagnostic, x-ray studies. However, when one or more sophisticated x-ray procedures are indicated, consultation is almost mandatory to determine if the procedure/s will be the most informative and if the cost and radiation exposure are justified.

Angiography

Angiography is a highly specialized, specific, generally available means of diagnosis and evaluation of a large number of congenital, developmental, degenerative, inflammatory, traumatic, and neoplastic lesions in every body system.

When the clinician considers an arteriogram for either diagnosis or treatment (embolization of bleeding sites or pharmaco-angiography), prior radiologic consultation is of utmost importance to derive maximum patient benefit from the procedure.

Abdominal angiography often is an important part of a diagnostic work-up, however, its position in the sequence of radiographic examination varies according to the clinical problem. For example, an acute, severe, gastrointestinal bleed may require diagnostic and/or therapeutic angiography as the initial radiologic examination, rather than barium studies, in this life-threatening situation. A chronic or repeat bleeder may be treated as an elective study at the conclusion of the barium studies but only after the complete elimination of barium from the intestinal tract.

The place of the arteriogram in the diagnosis of a renal mass also is variable. An intravenous pyelogram with laminography, ultrasonography, and percutaneous needle aspiration usually is sufficient for renal cysts, however, the arteriogram is very important in the evaluation of solid masses prior to surgery.

Not all hypertensive patients require a renal arteriogram, and the criteria are well established for proper selection of candidates.

It is our feeling that all intracranial and carotid vascular disease studies should have prior neurologic or neurosurgical evaluation. Availability of computed tomography (CT) has had a noticeable impact on the volume of intracranial arteriograms. The number of "survey-type" arteriograms has definitely decreased. As the confidence level in the CT scan increases, the arteriograms for evaluation of some intracranial mass lesions have been by-passed. If both studies are indicated, the CT scan should precede the arteriogram.

Venous studies, including obtaining direct venous samples (renin and parathyroid hormone assays), generally are considered elective procedures, but they can be performed most economically if done in conjunction with any contemplated arterial studies. The placement of umbrella filters in the inferior vena cava must be coordinated with the surgeon who will expose the jugular vein for cannulation.

Before performing peripheral vascular studies for occlusive disease or evaluation of mass lesions (bone or soft tissue), the radiologist should be made aware of the type of proposed surgical management to insure completeness of the angiographic procedure.

It is the radiologist's responsibility to obtain the so-called "informed consent" of the patient prior to any angiographic procedure. We often find that the patient has no prior knowledge of the proposed arteriogram other than the fact that "some tests" are going to be performed. The primary physician, with his established rapport with the patient, should discuss the nature of the procedure with him (or at least mention that the radiologist will do so), to prevent the complete surprise that otherwise occurs. It also is helpful if the primary physican mentions to his patient that there are some risks involved in the procedure; but that, in his opinion, the benefits will far outweigh the risks. This encourages the patient's acceptance of the study when it is explained to him in greater detail by the radiologist. This "team approach" usually results in less apprehension for the patient and works for the mutual benefit of everyone.

Mammography

The responsibility for the diagnosis of breast cancer rests on the primary care physician, and some knowledge and understanding of the place of mammography is essential. Radiologists stand ready to help in making the decision as to when mammography should be obtained.

First, it should be stated that the advantages of modern mammography (including xerography) outweigh any known radiation hazard and that mammography is an accepted part of the complete diagnostic work-up for women of any age in whom there is a clinical problem.

Routine screening has been questioned as a radiation hazard, but this study was based on large doses with extrapolation to small doses and on out-dated figures for the cancer-finding potential of modern mammography.

Firm criteria for screening are not available, but The American College of Radiology[1] recommends the following:

1. For asymptomatic women, the first or baseline mammographic examination should be performed between the ages of 35 and 40 years.

2. Subsequent mammographic examinations should be performed at one- to three-year intervals unless more frequent examination is medically warranted.

3. After age 50 years, annual or other regulated-interval mammography should be obtained.

Mammography has proved to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. In the Breast Cancer Detection Projects, of the 100 cancers found by mammography alone, most had negative axillary lymph nodes. Prior data would indicate an 85-percent survival rate for this favorable group.

Indications for mammography, according to Peck and Lowman,[2] include:

1. Preoperatively, in all women with clinically obvious carcinoma, mammography affords additional preoperative evaluation of the lesion. Moreover, mammography of the contralateral breast is essential to determine if there is a suspicious lesion that should undergo biopsy at the time of mastectomy. The incidence of simultaneous, bilateral cancers is approximately 2 percent.

2. Preoperatively, in all women more than 35 years of age with a clinically benign mass requiring excision, mammography may demonstrate an unsuspected malignant lesion elsewhere in the breast that should have a biopsy.

3. A palpable mass of uncertain nature. This will help to decide whether to aspirate, observe, or perform a biopsy.

4. Nodular, lumpy, or thickened breasts

5. Bloody nipple discharge

6. Subjective breast complaints, such as pain

7. Large, fatty breasts in which mammography may demonstrate a mass too deep to be palpable.

8. Before irradiation or chemotherapy for breast cancer, mammography may demonstrate malignant calcifications and masses. After treatment, a baseline study is indicated, followed by periodic mammography to detect recurrence.

9. Search for a primary site of malignancy in patients with palpable axillary nodes and no palpable breast mass and in patients with distant metatases (especially in bone) and no palpable breast mass.

10. Positive thermogram

11. Periodic study of patients in a high-risk group
    - A. Previous cancer of one breast
    - B. Family history of breast cancer (especially mother or sister)
    - C. Prior breast disease. Ductal hyperplasia and papillomatosis have a greater risk; the level of risk is not agreed on in fibrocystic disease.
    - D. Nulliparity. It is unfortunate that while nulliparous women have a significantly higher risk of breast cancer, their breasts are more difficult to examine, both roentgenographically and clinically.
    - E. Late age at birth of first child (after 28 years of age)
    - F. Early menarche or late menopause
    - G. Prominent ductal pattern on mammography. Detailed analysis and follow-up of patients with increased prominence and nodularity of the mammary ducts, carried out by Wolfe,[3] have shown that patients with ducts of this type have a significantly increased tendency to develop cancer of the breast.

Mammography is a safe procedure with the potential of being the first innovation in over 75 years for reducing the death rate of patients with cancer of the breast by early detection of this disease.

Nuclear Medicine

During the past 30 years, radioactive tracers have moved dramatically from the research laboratory to the patient's bedside; they now are considered a useful tool available to the clinician. A department of nuclear medicine can be found in almost every community hospital. The emergence of these studies has been the result of many factors, but most importantly:

1. Improved equipment which produces images faster and with better detail.

2. Commercial production and availability of radionucleides with short half-lives resulting in less patient radiation.

3. Development of safe radiopharmaceuticals which are deposited in "target" organs, whether they be liver, lung, brain, bone, or kidney.

4. Availability of trained physicians interested in the application of radionucleides to medical diagnosis.

Nuclear medicine offers a modality to evaluate soft tissues which frequently cannot be studied by routine radiography, eg, brain, liver, thyroid, and myocardium, as well as those structures visualized on radiographs—the skeleton and lung. Also, radioisotopes offer a noninvasive means of evaluating dynamic or physiologic functions such as cerebral blood flow, thyroid function, renal function, and lung perfusion. It is essential, however, that the attending physician consult with the nuclear physician and communicate to him the applicable clinical and laboratory data and the tentative clinical diagnosis. "Blindly" ordering and interpreting nuclear studies is wasteful and poor medicine. We compare it to performing a physical examination without the availability of the patient's history. For example, the result of brain scan frequently is negative early in a stroke syndrome, therefore, the referring physician should be aware that a brain scan becomes positive several days after the onset of symptoms. Accordingly, the nuclear physician should be informed of the time of onset of symptoms so that he can interpret the study correctly. Thyroid studies cannot be evaluated properly without knowing the history of previous surgery, palpatation of the gland, knowledge of exogenous thyroid administration, recent administration of iodine-containing contrast materials and other studies. It is imperative that thyroid studies be ordered at the proper time, and consultation with the nuclear physician is essential. The diagnostic yield of nuclear procedures is increased greatly if the referring physician will take a few moments to communicate with the physician responsible for performing and interpreting these studies.

Perfusion lung scans have become the primary screening study for evaluation of pulmonary emboli. The injec-

tion of technetium-tagged microemboli provides a rapid, noninvasive means of visualizing lung perfusion abnormalities. The perfusion defects are nonspecific and can be the result of other disease processes such as pneumonia, pleural fluid, atelectasis, previous surgery, or tumor. The referring physician should be aware of these differential possibilities. Chronic, obstructive, pulmonary disease will produce similar perfusion defects as a result of focal or segmental areas of anoxia, and perfusion must be interpreted with this in mind. A chest radiograph, xenon inhalation studies, and history of chronic lung disease are helpful in evaluation of perfusion defects.

If possible, abdominal nuclear studies should precede barium studies since barium retained in the colon can produce a defect on a liver image. Interfacing and planning diagnostic work-ups are mandatory. Thyroid studies should precede IVP or gallbladder studies; liver and bone scans should precede barium studies of the gastrointestinal tract; and brain scans should be made before cerebral angiographies. Your nuclear physician will advise you on the best program for planning a diagnostic work-up.

Bone scans are an accurate, low-radiation means of surveying the skeletal system for metastatic disease, Paget's disease, or fractures (at the appropriate interval after injury), and other diffuse bone diseases. In our laboratory, we recommend a bone scan prior to a radiographic bone survey, and then obtain only appropriate radiographs of positive areas indicated on the bone scan. This is a less expensive, higher yield, and lower radiation program for the patient. However, correlation with radiographs is essential since the bone scan may be nonspecific.

In our experience, liver scanning has been most helpful in evaluating metastatic disease, hepatic trauma, abscesses, and presence, as well as severity, of cirrhosis. Liver defects are nonspecific and must be correlated with liver function studies since liver cysts can produce identical defects, and, conversely, diffuse metastatic disease may produce only nonspecific hepatic enlargement.

On the horizon are many exciting new radiopharmaceuticals and improved scanning equipment which will offer the physician better tools for patient care and diagnosis. These include cardiovascular (nuclear medicine) myocardial perfusion (myocardial imaging and nuclear angiography), gallium scanning for malignant disease, radioimmunoassay procedures, cisternal scanning for communicating, low-pressure hydrocephalus and many others. Although sophisticated and accurate nuclear procedures are now available to the referring physician, they are of diminished value without communication and consultation with the referring physician. There must be correlation with other imaging modalities such as radiography, ultrasound, and computed tomography (CT). The major thrust of this glance at nuclear medicine is a plea for an open line of communication between the referring physician and the nuclear physician so that diagnostic studies can be properly planned, requested, and interpreted. It is our responsibility to spend the medical dollar wisely and economically and, simultaneously, to provide the patient with the best possible care. (See the editorial, "The Radiologist and His Fellow-Physicians," page 393.)

Ultrasound

In the past several years, two new diagnostic-imaging modalities have come into clinical use augmenting our radiologic armamentarium — diagnostic ultrasound and computed tomography.

In ultrasound, high-frequency sound waves are used to obtain imaging information. These waves are generated by a piezoelectric crystal in a transducer. The waves are focused and then passed into the body in a thin beam which looks at a thin tissue slice much like the x-ray technique of laminography. Echoes formed at tissue interfaces are reflected to the transducer. These echoes are then processed electronically and are presented as a video display which can be recorded on film.

The examinations are noninvasive; there is no patient discomfort. In addition, it is important to note that as no ionizing radiation is used, there is no radiation exposure to the patient.

The most common use of ultrasound is in B-mode scanning in which a two-dimensional image of a tissue plane is created. There are widespread applications for this mode which are confined principally to the abdomen and pelvis. It has found considerable application in the study of the gravid uterus. With ultrasound, we can establish accurate measurement of various fetal parts (biparietal diameter, fetal thorax), thereby establishing the age of the fetus. Placental localization (of value before amniocentesis, possible placenta previa) also is easily established with ultrasound. Many uterine and fetal abnormalities can be detected also.

Similarly, ultrasound has been quite useful in evaluating gynecologic problems. For example, it can readily evaluate whether an adnexal mass is solid, cystic, or a combination of the two. One of the principal functions of ultrasound in any part of the body is in the evaluation of the internal consistency of a mass.

In the upper abdomen, ultrasound is useful in evaluating liver masses, the gallbladder (especially one not visualized by conventional radiographic methods), the biliary tree, and the pancreas.

Ultrasonic evaluation of the retroperitoneal area is commonly used for evaluating renal mass lesions and other masses such as lymphoma. It also has become the diagnostic modality of choice in evaluation of the aorta for aneurysmal dilation.

Other B-mode applications in diagnostic work include evaluation of the thyroid, the eye, and orbit.

Proper use of ultrasound in a clinical setting is best achieved by the clinician consulting with the attending radiologists before ordering the examination. Proper interfacing of ultrasound examinations with other radiographic and isotope procedures by the radiologist is imperative in order to gain the maximum amount of information in the shortest period of time.

The Radiologist and His Fellow-Physicians

When a patient is short-changed for his radiologic dollar, one of the more likely causes is the unhealthy relationship between the radiologist and the referring physician. If the radiologist were magically transformed into the clinician, but retaining his radiologic "know-how," he would sit on the doorstep of his radiologist detailing the problems of his patient and the specific solutions desired. Later, he and the radiologist would review the examination with a brisk give and take, bringing the clinician's skills and awareness of the clinical problem to bear on the final interpretation. Thus, a rational diagnosis of cancer of the pancreas would be possible in the elderly anorectic lady who is losing weight, has a suspicious fullness in the left upper quadrant but a radiologically normal gut, but a little notching of the left ureter during the intravenous pyelogram: the notches represented the collateral portal return around the thrombosed splenic vein sitting atop the infiltrated pancreas. Scribbling the name of the examination on a prescription blank fails to give radiology the status of a consultative service it deserves for the welfare of the patient.

The deepest rung in purgatory must be reserved for the clinician who withholds vital clinical information to test the radiologist's objectivity.

Many a clinician does not know he is the single most important source of the radiologist's continuing education. How else can you explain his frequent lapses in giving the radiologist vital followups in clinical problems, either by word of mouth or by summons to the operating or endoscopy theaters? Only the clinician has the power to transform the radiologist's repetitive bungling into sound experience.

Nor can the radiologist be left "off the hook"; one who avoids his clinical colleagues because he fears encounter, or is too busy or too bored, should be drummed out of the corps. Nor can he tolerate a technical and clerical staff who regards the visiting clinician as an intruder upsetting their comfortable routine.

The radiologist's specialty certificate does not automatically make him a consultant. The road to consultant status is long and rough, the climb is steep, and the top is never reached. New, difficult stretches are forever being added, the last being clinical immunology. The essentially contemplative nature of our specialty gives us time for the climb, more than most specialties, and if we fail to make it we are being unfair to the patients, our colleagues, and ourselves. Lister's words to his colleagues are especially applicable to us radiologists: *"You must be students, learning and unlearning till your life's end, and if, gentlemen, you are not prepared to follow your profession in this spirit, I implore you to leave its ranks and betake yourself to some third-class trade."*

And Maimonides put it even more poetically: *"May there never develop in me the notion that my education is complete but give me the strength and leisure and zeal continually to enlarge my knowledge."*

When the clinician fails to recognize radiology as a consultative service, his attitude can be traced to his mentor at the medical center, and ultimately to the radiology department of the institution where his mentor trained. A strong chief of radiology, finely attuned to the intricacies of clinical medicine and pathology, soon communicates to the clinical staff that indeed he has much to contribute, and the more help he gets from the clinician, the more he can contribute. Only a weak radiologist would have allowed nurture of the doctrine: "You make the films, Doc, and we'll read them."

What can the radiologist do when confronted by this otherwise superbly trained young addition to the clinical staff, but trained in a center where the radiology department was never fully utililized? This young doctor, entering an alien environment, is more receptive at this time than at any other time in his professional life to help and advice tactfully offered. When shown illustrative material from the teaching file, he will see the wisdom of routinely combining the gallbladder and gastrointestinal studies, or the barium enema with the intravenous pyelogram. He will see the lack of necessity, even the harm, in specifying technical details of the radiologic examination (without prior consultation), such as specific views or kind of contrast material. He will see that when the radiologist is apprised of the clinical problem, he may offer a radiologic solution both medically sane and sparse of roentgens and dollars.

Such close relationship between the referring physician and the radiologist is necessary for the better care of the patient.

CHRISTIAN V. CIMMINO, M.D.

(Reprinted from the *Virginia Medical Monthly,* Volume 103, Number 2, February 1976.)

Computed Tomography (CT)

The newest radiologic technique is commonly known as computed tomography (CT). Other terms for the same technique found in the literature include computerized axial tomography and computer assisted tomography (CAT) lead to some confusion, but it is anticipated that soon everybody will be using the term computed tomography (CT). Since the introduction of this technique into this country in 1972, it has become the standard of medical care for many patients with neurologic disease. Its use in other parts of the body (abdomen, pelvis, thorax, and skeletal system) is not so well established but is rapidly advancing. Herein we shall attempt to outline some of the present indications and limitations of this technology.

Some of the suspected medical conditions considered as indications for referring patients for computed tomography (CT) are:

1. Stroke (infarct)
2. Brain tumor (primary, metastatic)
3. Headaches of unusual nature or duration.
4. Aneurysm (The aneurysm must be quite large to be seen on CT).
5. Subarachnoid hemorrhage
6. Meningitis
7. Cerebritis
8. Brain abscess
9. Congenital malformations
10. Hydrocephalus
11. Arteriovenous malformation
12. Shunt evaluation

The amount of radiation received during the CT procedure of the head is essentially the same as that of a routine radiographic examination of the skull.

In other areas of the body, the indications for CT scanning are more limited; the referring physician must always discuss considered medical indications with the radiologist prior to requesting this expensive and time-consuming examination. In general, the CT scan has been most successful in the retroperitoneal organs and in the

pelvis. Rarely, it may be useful in evaluating liver disease. As scanning times become more rapid and additional experience is gained, indications will continue to increase. The organs and some of the conditions that may be evaluated by CT scan are:

1. Pancreas — tumor, cyst, pancreatitis
2. Liver — obstructive jaundice, fatty infiltration, tumors. (Cirrhosis is better evaluated by isotope scans.)
3. Kidney — cysts, tumors, nonvisualization of collecting system on excretory urogram
4. Uterus and ovaries — (Ultrasound is better generally, if available.)
5. Aorta — Aneurysms are seen well, but ultrasound is as good and less expensive.
6. Enlarged lymph nodes and other retroperitoneal masses
7. Prostate — CT may show tumor breaking through capsule.
8. Mediastinum and pleura-mass lesions
9. Skeletal system — evaluation of osteoporosis and obscure congenital anomalies or neoplastic lesions

Motion artifacts are the single greatest reason for poor scans. The referring physician should alert the patient to the fact that he must remain motionless during the procedure. If the patient will require sedation to remain motionless for CT scanning, this should be arranged by consultation with the radiologist well in advance of the examination.

Respiratory motion produces artifacts in the abdomen. This is less of a problem with the newer, more rapid scanners. Even peristaltic motion of gas in the intestine seriously degrades the image. Scans of the abdomen are rendered almost useless by the presence of residual barium or surgical clips in the area to be scanned. Before sending a patient for CT scanning of the abdomen, a scout radiograph should be obtained to be certain there is no residual barium if the patient has had a barium study one or two weeks previously.

More than half the scans will require injection of contrast material of the same type as that used in the excretory urogram but usually in larger volumes and concentrations. The patient should be told that he may receive an injection and that this will produce a marked sensation of warmth. The referring physician should be aware that the risk of fatal reaction to the contrast material for CT studies is essentially the same as for excretory urography.

There is great enthusiasm for this newest radiologic technique but since much of CT scanning is new, it is most important for the referring physician to confer with the radiologist before submitting a written request for a CT scan. This will insure that the patient has the proper examination with minimal expense and inconvenience.

Radiation Therapy

Radiation therapy is a highly developed specialty in the field of oncology. It requires broad and detailed knowledge of the diagnosis and treatment of cancers and a basic understanding of cancer biology. Radiation therapy, for practical reasons, optimal use of professional staff and equipment, and economy consistent with high quality care, is best performed in a few medical centers within a regional area. It is primarily a tertiary-care specialty where close interdisciplinary cooperation with its counterparts in surgery, medicine, and pathology are available to assure the best care for the patient with malignancy.

The radiation therapist makes himself readily available for consultation with the primary physician concerning management decisions, both diagnostic and therapeutic, for his patient with cancer. It always is advantageous to render this consultation after personally examining the patient. However, it often is possible to carry out the consultation by means of telecommunication with the primary physician in the outreach area. Under these circumstances, the decisions can be made as to what further diagnostic or therapeutic procedures should be carried out at the local level or whether the patient should be referred to a larger institution for the studies. After reviewing the case history, he may recommend that the patient see a medical or surgical oncologist in consultation. The radiation therapist often is in a position to make these arrangements if the patient is to be seen at the larger center.

Limited radiation therapy facilities do exist—and will continue to exist—in many community hospitals with a general radiologist performing part-time radiation therapy. The radiation therapist frequently serves as a consultant to these radiologists in the outreach areas. This is very important for through this mechanism many patients, especially those for palliation, can be treated at the community hospital with back-up support from all of the facilities of the cancer center. The type of cancer and the treatment planned, of course, would depend upon the equipment available in the community hospital.

For this purpose, radiation therapy can be divided into four categories:

1. Superficial therapy — ionizing radiation with energies from 30 to 140 kilovolts. As the term applies, these are relatively soft x-rays and are used for noninfiltrating cancers, such as skin cancers.

2. Orthovoltage therapy — ionizing radiation with energies from 150 to 400 kilovolts. This equipment has been replaced largely by megavoltage units. It is used in the treatment of infiltrating surface malignancies and often as a supplement to megavoltage therapy (such as interoral and intervaginal treatment).

3. Megavoltage therapy — ionizing radiation of greater than one million volts. This includes cobalt 60 and a variety of accelerators using high-energy x-rays. The term cobalt therapy enjoys the reputation as being synonymous with all megavoltage therapy. This, of course, is not true. Cobalt 60 units are excellent for the out-of-reach community hospitals since they require very little mainteance and have very little "down" time. In addition to cobalt, most of the radiation therapy centers have the more sophisticated accelerators which deliver radiation at 4 to 12 million volts. A few of the large centers have accelerators and betatrons which produce 25- to 35-million-volt x-rays.

4. Brachytherapy — ionizing radiation using radium or the equivalent, or radioactive cobalt, cesium, or iridium. These isotopes are used in the form of needles for implantation of tumors, or in applicators to be placed against the tumor or inserted into a cavity containing a tumor.

In addition to being the treatment of choice in many cancers, radiation therapy is used in combination with chemotherapy and as a preoperative or postoperative therapy. The radiation therapist readily avails himself for tumor conferences, tumor boards, and lectures especially in those communities where no radiation therapy facility exists. Through this mechanism, the primary physician can keep abreast of the current trend, results, and management of the patient with cancer treated with radiation therapy.

Since the radiation therapist is a tertiary-care physician, he relies heavily on the primary physician for the general supportive medical care essential to keep the cancer patient a functioning individual in the interval when he is receiving radiation therapy.

It should be stressed that radiation therapy rarely is used in the treatment of benign processes. It is used for radiation castration and to prevent keloid formation. Occasionally, refractory inflammatory conditions, such as suppurative adenitis or parotitis, plantar warts refractory to other treatments, and recurring, acute, calcific tendinitis, are benefited by it.

Conclusion

This overview of radiologic services also could have included these additional procedures: intravenous and percutaneous cholangiography, percutaneous common-duct-stone removal, splenoportography, lymphangiography, laminography, needle aspiration and biopsy, sialography, percutaneous bronchograms, and pneumoarthrography. These diversified, often sophisticated, services that are available to referring physicians for better care of their patients present an imposing armamentarium. We have not included the numerous entities which present contraindications or demand extreme caution in the use of certain contrast materials. These include: bronchial asthma, allergy, hypersensitivity to iodine, hepatic or renal disease, multiple myeloma, pheochromocytoma, sickle cell anemia, and pregnancy. Referring physicians should be responsible for informing their radiologic colleagues of any such existing condition. For the best medical practice at the least cost, we urge you to use these many services judicially and in close cooperation with the radiologist.

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What the osteoarthritic patient perceives as "feeling better"...

Please see last page of advertisement for summary of prescribing information.

THE OHIO STATE Medical Association

Pharmacology Today

Management of the Drug Overdose Patient

Part I. Discussion of General Principles

Joseph R. Bianchine, M.D., Ph.D.
Daniel Couri, Ph.D.

IN THE UNITED STATES, about 6,000 adults die each year from drug poisoning. Many drug overdosed patients are seriously ill and require immediate and authoritative management. This, the first of two articles, summarizes an immediate, general approach to the seriously poisoned patient. The second one will review important, specific antidotes useful in certain types of drug intoxication.

When first presented with such seriously poisoned patients, it is essential that the physician efficiently utilize every available moment. First things first! A useful check list for consideration (the ABCs and Ds of *coma* care) are:

1. *Airway.*— Is the airway patent? Foreign body blocking flow of air? If blocked, airway must be made patent before considering the next step.

2. *Breathing.*— Is the chest wall moving properly and effectively? Is air moving in and out of lungs adequately? If not, initiate artificial respiration.

3. *Circulation.*— Is there an effective pulse beat present? Is the blood pressure sufficient to perfuse tissues adequately?

4. *Definitive Diagnosis and Treatment.*— A large needle should be place in a vein, blood withdrawn for hematology, chemistry, and toxicologic assays, and an intravenous drip begun to keep open this ready access to the circulation. Hematocrit, blood acetone, and blood glucose levels should be determined immediately for any patient with coma of unknown etiology. Serum urea nitrogen, serum sodium, and serum calcium levels also are important clinical determinations in this setting. Every comatose patient in whom diagnosis is not initially evident should be treated with intravenous hypertonic glucose because of the real and treatable possibility of hypoglycemia. Urine and vomitus should be saved for possible toxicology assay, if needed. While the laboratory personnel are toiling over the specimens sent to them for assay, seek out diagnostic clues on physical examination.

Causes for depressed consciousness are many and varied. A thorough and systematic approach to acute diagnosis always is essential. Be wary of the possibility of multiple drug intoxication. When drug poisoning appears likely, the following principles should guide your management.

Principle 1. Prevent Further Absorption of Unabsorbed Drug Remaining in Gut Lumen

Ingested poisons can be removed from the stomach by emesis or by gastric lavage. The efficacy of the procedures depends upon the time interval between ingestion and removal attempt as well as rapidity of absorption of the drug in question. Usually, very little drug remains in the stomach for more than four hours. However, delayed gastric emptying associated with deep coma, shock, or pylorospasm can cause retention of drug in the stomach for longer than four hours.

Ipecac.— A useful drug for induction of emesis. It is inexpensive, stores well, and can be administered at home by lay people. Give syrup of ipecac, 15 to 20 ml, by mouth, and follow with large amounts of whatever fluid the child will drink. (Action of ipecac is less effective on an empty stomach than on a full stomach.) Vomiting usually occurs within ten minutes. Syrup of ipecac is available without a prescription and should be in the medicine cabinet for such emergencies in families with toddlers.

Apomorphine.— Induces vomiting more readily than ipecac, but it presents several disadvantages. It does not store well, it is a narcotic drug, and it must be administered parenterally. Apomorphine should not be administered unless a reversing narcotic antagonist (naloxone) is available, if needed.

If the patient critically requires an emetic, this preparation can be given intravenously, otherwise, it is administered subcutaneously. Emesis usually ensuses within 5 to 15 minutes. Be wary of repeating the dose of apomorphine since it has central depressant action which acts synergistically with other depressant drugs. Naloxone (Narcan®),

Dr. Bianchine, Columbus, Chairman and Professor, Department of Pharmacology, and Professor, Department of Medicine, The Ohio State University College of Medicine.
Dr. Couri, Columbus, Professor of Pharmacology, and Director, Toxicology Division, The Ohio State University College of Medicine.
Submitted February 23, 1977.

0.1 to 0.2 mg, can be given parenterally as soon as adequate emesis has been obtained to prevent continued nonproductive retching. Emetic drugs should not be administered to an unconscious patient because of the risk of gastric juice aspiration.

Gastric Lavage.— Many of the cautions noted for the use of emesis also apply for gastric lavage. Clinical judgment must be used in deciding if the benefits of lavage outweigh its dangers. The risk of aspiration in the unconscious patient is reduced by placement of a cuffed endotracheal tube prior to gastric lavage.

Lavage should be continued until all particulate material is removed. Once lavage is completed, place activated charcoal into the stomach if the suspected ingestant is charcoal absorbant.

Principle 2. Hasten Metabolism and Elimination of Absorbed Drugs

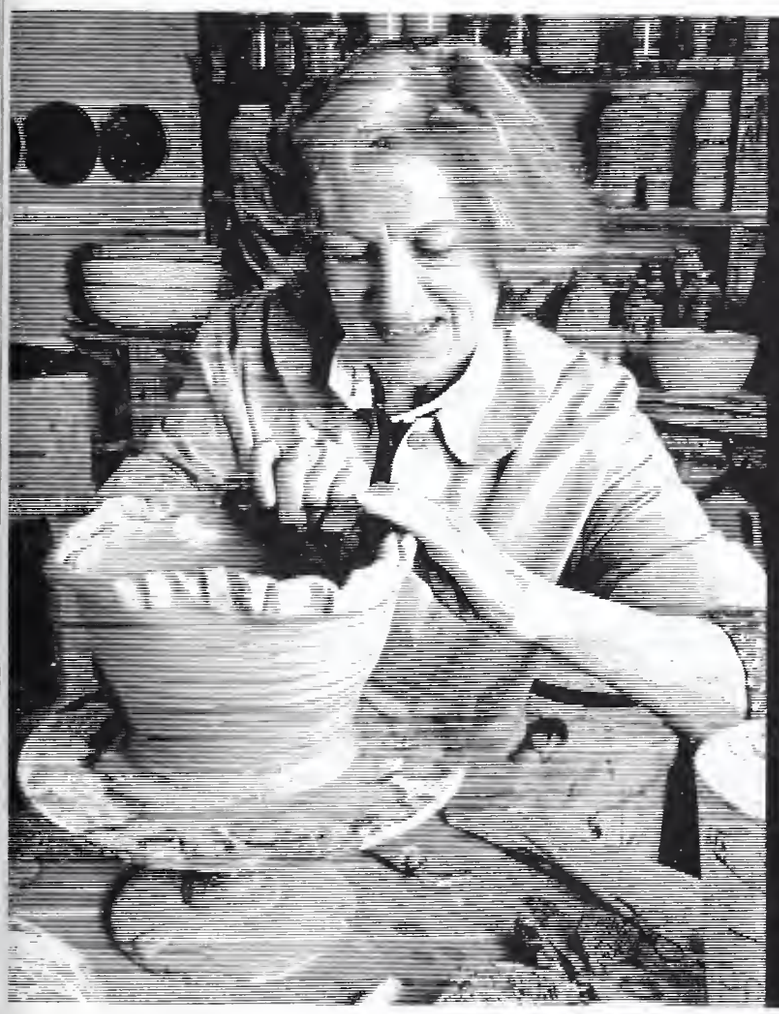
Poisons absorbed into the body can be inactivated effectively by several mechanisms including (a) metabolism to inactivate metabolites by the liver, (b) binding of active drug to protein or lipid-binding sites, and (c) excretion of active drug by the kidney. Maintenance of proper oxygenation, temperature, and perfusion of vital organs is obviously important in maintaining these normal detoxication mechanisms. Excretion of many drugs is assured by maintenance of a brisk urinary output. Further, with certain drugs, excretion can be hastened by taking advantage of its pH-solubility characteristics. For example, alkalinization of urine, coupled with enhanced diuresis, is useful in intoxications with weak acidic drugs such as phenobarbital and aspirin. On the other hand, acid diuresis may hasten elimination of weak basic drugs such as amphetamine, quinidine, or strychnine.

Alkaline diuresis can be instituted by the intravenous administration of sodium bicarbonate, while acid diuresis may be accomplished by the administration of ascorbic acid, arginine, or ammonium chloride.

Dialysis.— Hemodialysis or peritoneal dialysis represent other means by which removal of drug from the poisoned patient can be facilitated. Dialysis should be considered when the toxic manifestations are related to the blood concentration of the toxin, the toxic substance is dialyzable from the vascular compartment, and the patient has not responded to conservative measures.

Specific, effective antidotes are available for only a few drugs. This aspect of management of the drug overdose patient will be presented next month as Part II of this article.

Generic and Trade Name of Drug
Naloxone hydrochloride— Narcan (Endo Laboratories)



What the osteoarthritic patient perceives as "feeling better?"..

Please see last page of advertisement for summary of prescribing information.

THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, April 2, 1977, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present were: All members of the Council with the exception of Drs. Maurice F. Lieber, C. Edward Pichette and S. Baird Pfahl, Jr.); James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Dr. P. John Robechek, Cleveland, Chairman of the Ohio Delegation to the AMA; Drs. Oscar W. Clarke, Gallipolis; Henry A. Crawford, Cleveland; Jerry L. Hammon, West Milton; Robert N. Smith, Arlington, Virginia; Richard L. Fulton, Columbus; Charles L. Hudson, Cleveland, and Charles Jaeckle, Defiance, all members of the Ohio Delegation to the AMA; Dr. Paul S. Metzger, Columbus; David L. Rader, Columbus, Vice President/Administration, The Physicians Insurance Company of Ohio; and Messrs. Page, Gillen, Campbell, Clinger, Mulgrew, Holcomb, Ayish, Torrens, Mrs. Wisse, Mrs. Dodson, Ms. Doll, Mrs. Jacobson, and Mrs. Franklin, of the OSMA Staff.

MINUTES

The minutes of the February 19-20, 1977 meeting **were approved.**

MEMBERSHIP

Membership statistics were reported by Mrs. Wisse.

AMERICAN MEDICAL ASSOCIATION

The April 1, 1977 meeting of Ohio's Delegation to the AMA was reviewed by Dr. Robechek and Mr. Campbell.

The Council elected Dr. Robechek as delegation chairman, and Dr. Clarke as vice-chairman. Both were nominated by the delegation. The president of OSMA serves as co-chairman, in accordance with the delegation's "organization structure and Rules and Regulations."

Dr. Robechek appointed the following committee chairmen: Dr. Hines, hospitality; Dr. Crawford, resolutions; and Dr. Clarke, elections and candidates.

The Council endorsed Dr. John Beljan for a position on the Liaison Committee on Medical Education of the AMA.

AD HOC COMMITTEE ON AMA DELEGATES

The Ad Hoc Committee on AMA Delegates reported on its assignment to determine which delegates and alternates would represent Ohio at the AMA in the event the Ohio AMA members count falls below the number required to permit a given number of delegates and alternates.

Dr. Dorner, the chairman, brought several alternatives to the Council and it was decided to accept the following: Two alternate delegates of the entire delegation with least amount of tenure would be placed in inactive status; one delegate of the entire delegation with the least amount of tenure transferrd to alternate-delegate status. If, in second year of the term, AMA membership increases sufficiently, the alternates on inactive status revert to active status and the delegate serving temporarily as alternate returns to full delegate status; in case of same tenure, changes to be decided by flip of coin.

The concept was referred to legal counsel for drafting of a resolution for introduction at the 1978 Annual Meeting.

OHIO HEALTH DATA CORPORATION

At the invitation of the Council, Dr. Paul Metzger discussed the objectives of the proposed Ohio Health Data Corporation.

Subsequently, the Council voted to become an incorporator and member of the corporation, with the proviso that those who represent the OSMA on the Board of Directors of the Ohio Health Data Corporation are not authorized to obligate the OSMA to any financial commitment.

Drs. Hartle and Diller were named as OSMA representatives.

OHIO MEDICAL INDEMNITY, INC.

Dr. Bates reported the nominating committee had recommended the following persons be nominated and elected to the OMI Board of Directors for the ensuing year: Ben Arnoff, M.D., Columbus; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; Albert A. Brust, M.D., Dayton; Joseph D. Cionni, M.D., Cincinnati; Guerney H. Cole, Jr., Middletown; L. Eugene Duff, Lima; Milton M. Gatch, Owensville; W. D. Henceroth, D.O., Grove City; Paul A. Jones, M.D., Zanesville; James B. Ogden, Columbus; Martin R. Otto, Warren; James G. Roberts, M.D., Akron; Frank D. Robinson, Canton; William R. Schultz, M.D., Wooster; Robert N. Smith, M.D., Arlington, Virginia; William E. Sovik, M.D., Youngstown; Phillip W. Tefft, Columbus; M. M. Thompson, M.D., Maumee; and James F. Zeller, M.D., New Philadelphia.

By official action, the Council **approved** the nominations presented and authorized the following persons to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting, including the election of directors placed in nomination by the

Council at this meeting, on April 2, 1977: William M. Wells, or Robert G. Thomas, or William Dorner, Jr., or W. J. Lewis.

PHYSICIANS INSURANCE COMPANY OF OHIO

Mr. Rader reported on the actions taken at the April 1, 1977 meeting of the Board of Directors of Physicians Insurance Company of Ohio.

He announced the Board had received a report on the results of the recent survey of the OSMA membership with regard to their interest in purchasing other lines of property and casualty insurance in addition to professional liability and that the members replying overwhelmingly expressed an interest in purchasing such insurance if it were made available through PICO.

At its April 1 meeting the PICO Board **approved** a proposal to extend the scope of insurance offered to other property and casualty lines, including homeowners' and automobile insurance. The Board further acted to **not** require an OSMA member to own stock in order to purchase the lines of insurance other than professional liability; and decided that the new insurance lines, as well as excess coverage on professional liability policies, would be, when available, offered through designated agents.

Mr. Rader also reported that approximately $4½ million of authorized Class A Shares have been sold and that gross premium income from December 27, 1976, to date, is approximately $4½ million.

COMMITTEE REPORTS

Joint Advisory Committee on Sports Medicine

Minutes of the February 22, 1977 meeting of the Joint Advisory Committee on Sports Medicine were reviewed by Mr. Clinger. It was pointed out that the committee is operating through five subcommittees: (1) Awards, (2) Education, (3) Play-off Coverage, (4) Policies and Guidelines, (5) Specialized Sports.

The minutes were accepted.

Committee on Health Manpower

Minutes of the March 2, 1977 meeting of the Committee on Health Manpower were reviewed by Mr. Clinger.

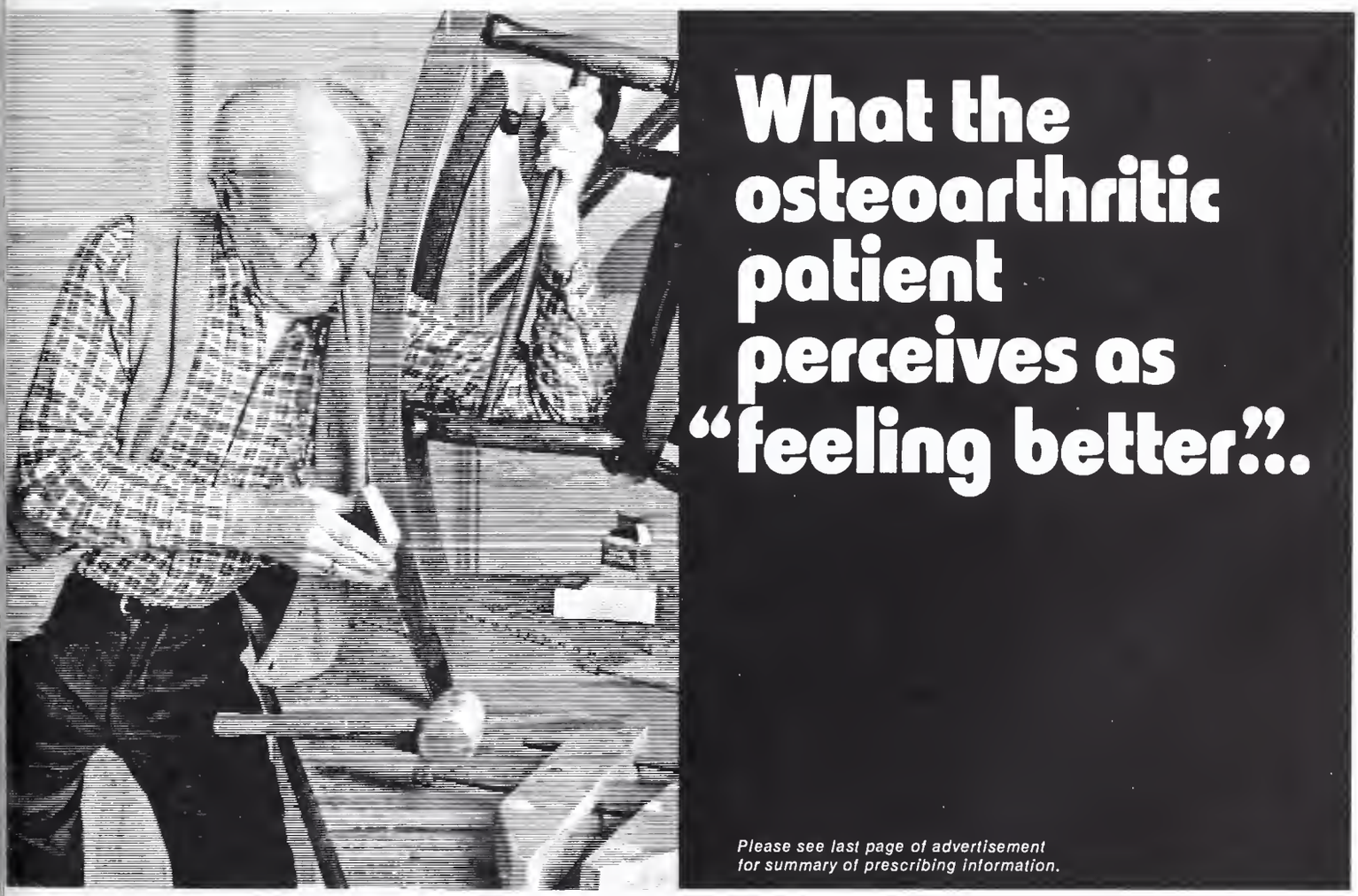
Recommendations concerning *S.B. 130,* legislation pertaining to anesthesia assistants, and *H.B. 209,* which would establish a board of physical therapy, were received by the Council, and policy was voted when the proposals were discussed in connection with the report of the Department of State Legislation.

The minutes, as a whole, **were approved.**

Committee on Eye Care

The March 6, 1977 meeting of the Committee on Eye Care was discussed by Mr. Ayish.

(continued on page 400)



Proceedings of the Council *(continued)*

A number of legislative issues were covered in the committee's deliberations. The Council studied these issues during the State Legislative Department's report and voted on policies at that time.

The minutes were accepted as presented.

Committee on Emergency and Disaster Medical Care

Minutes of the March 12, 1977 meeting of the Committee on Emergency and Disaster Medical Care were reviewed by Mr. Torrens.

The Council noted the committee's request for a policy statement on the relationship between physicians, Emergency Medical Technicians-Paramedic's and Emergency Medical Technicians-Ambulance's in an emergency situation within the physician's office and asked that the committee present for Council consideration suggested wording for such advice.

The Council **approved** a committee recommendation "that physicians have practical knowledge of Basic Life Support and Advanced Life Support, and have their office personnel trained in what to do in case of emergency in the office."

Basic Life Support and Advanced Life Support courses at the Annual Meeting were encouraged.

A suggestion that OSMA support legislation to permit the waiver of regulations requiring 20 hours of in-hospital training until the EMT is certified, was accepted.

The minutes, as a whole, **were approved.**

Commission on Medical Education

Minutes of the March 16 meeting of the Commission on Medical Education were reviewed by Mrs. Dodson.

The Council accepted a recommendation for seeking "common ground" in working with the Ohio Osteopathic Association with regard to continuing medical education.

The Council voted to **approve** changing the OSMA recognition award to conform with the wording on the AMA-PRA award certificate.

The minutes, as a whole, **were approved.**



LEFT TO RIGHT: James E. Pohlman, Esq.; William M. Wells, M.D.; D. Brent Mulgrew, Esq.; George N. Bates, M.D.; Hart F. Page, C.A.E.; and Richard A. Ayish.

Committee on Government Medical Care Programs

Minutes of the March 24, 1977 meeting of the Committee on Government Medical Care Programs were reviewed by Mr. Gillen.

The minutes indicated that the members of the committee will individually review the *New Medicaid Handbook* so that deficiences can be remedied.

The Council received the report of a proposed new Ohio Department of Medical Services, which would take over many of the responsibilities of the Ohio Department of Health and the Ohio Department of Welfare.

The members of the Council expressed general opposition to the measure as presented, because of its wholesale infringement on the Ohio Department of Health and the Ohio Public Health Council. Some reorganization of the payment functions of several State programs, on the other hand, might well be indicated, according to the Council.

The Council endorsed a recommendation of the committee that physicians be asked to cooperate for a 12-months' trial period, with a program involving a Revised Medical Assistance Identification Card for Medicaid recipients.

The card would provide a place for the physician to indicate dates of service to a patient, and the number of prescriptions he has prescribed for him on a given date. Space would also be provided for the pharmacist to indicate dates and number of prescriptions filled.

The purpose of the program is pointed toward cuting down patient over-utilization of these services.

The minutes, as a whole, **were approved.**

Committee on School Health

The minutes of the March 30, 1977 meeting of the Committee on School Health were presented by Mr. Clinger.

A state-wide immunization program was discussed and the committee to organize the campaign was announced, with Mr. Clinger designated to represent the OSMA.

The Council **approved** committee suggestions with regard to the sponsors of projects seeking endorsement of OSMA, that the endorsement of the county medical society/societies of the area be sought in the first instance.

The Ohio School Screening Program for Scoliosis was endorsed.

The minutes, as a whole, were accepted.

Committee on Prisons and Jails

The minutes of the March 30, 1977 meeting of the Committee on Prisons and Jails were reviewed by Mr. Gillen and were accepted.

FIELD SERVICE

Mr. Holcomb reported that much more activity is occurring in the area of physician placement. He indi-

cated that students are much interested in finding financing from communities in face of rising tuition costs.

OTHER MEETINGS

Mr. Holcomb discussed a meeting with house staff representatives and Mrs. Dodson on February 24; a Negotiations Seminar sponsored by OSMA on March 26-27; and a meeting with Ohio's County Medical Executives on March 30.

Mr. Torrens reviewed an OSMA-sponsored Financial Control Workshop on March 22.

PUBLIC RELATIONS

Ms. Doll announced that a press conference on the Blackwell Report *(Public Attitudes Toward Physicians and Malpractice Problems)* will be held on Monday of the Annual Meeting and that the written report will be available to supplement Dr. Blackwell's remarks at the House of Delegates.

TASK FORCE ON PROFESSIONAL LIABILITY

Mr. Campbell announced that a 20-page report has been prepared by the Task Force on Professional Liability for presentation to the House of Delegates and the entire OSMA membership.

He announced that the membership survey on the question of whether PICO should offer other lines of property and casualty insurance in addition to professional liability insurance is overwhelmingly positive.

LEGAL COUNSEL REPORT

Mr. Pohlman reported on the Mahoning County Medical Society antitrust litigation in Federal District Court and his visit with the Society's attorneys in Youngstown to discuss the litigation.

After an extensive report from Mr. Pohlman, the Council voted to approve a statement to be finalized by legal counsel with regard to medical service review of complaints from patients and physicians on fee matters and excluding consideration of complaints from third party carriers.

The Council voted to withdraw Resolution No. 63-77.

CONSTITUTION AND BYLAWS

The amendments to the Summit County Medical Society's Bylaws were considered and legal counsel was directed to continue discussions with officials of the Society with regard to one aspect of the amendments dealing with membership qualifications.

JOINT UNDERWRITING ASSOCIATION

Mr. Campbell presented current J.U.A. statistics re-

(continued on page 402)

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garding matters such as premium income, claims, number of participants, etc.

FEDERAL LEGISLATION

The federal legislative report was presented by Mr. Campbell in the absence of Mr. Edgar.

STATE LEGISLATION

The report of the Department of State Legislation was presented by Mr. Mulgrew and Mr. Ayish.

S.B. 45 and *H.B. 151,* drug substitution measures:

It was pointed out that the Senate version is moving toward the floor. Mr. Mulgrew thanked Dr. C. Douglass Ford, Dr. Charles L. Hudson, and Dr. Richard Dorsey for their service as witnesses before House Judiciary and Senate Health & Retirement Committees.

Four of five OSMA amendments were adopted in Committee, but the bill is still unsatisfactory to the OSMA. Strong backing by organized labor and senior citizens is moving the bill according to Mr. Mulgrew.

ACTION: Council voted to continue opposition.

S.B. 163, to permit optometrists to use diagnostic drugs and to expand definition of optometry:

ACTION: Opposed use of diagnostic drugs by optometrists and will oppose the expanded definition of optometry in S.B. 163.

H.B. 115 and *H.B. 185,* to repeal Ohio's motorcycle helmet requirement law:

ACTION: Council voted to oppose these bills due to the medical and economic implications.

S.B. 130, anesthesiologist assistants bill:

ACTION: Voted a neutral position.

S.B. 202, "Patients' Bill of Rights" proposal:

ACTION: Voted continued opposition.

H.H. 213, bill to repeal the statutory "informed consent" form:

ACTION: Continued support if properly amended.

H.B. 443, to require establishment of primary care residency programs in state-supported schools of medicine:

ACTION: Maintain observation and monitoring, pending funding proposals.

H.B. 209, physical therapy board bill:

ACTION: Continued opposition unless appropriately amended.

H.B. 298, determination of death bill:

ACTION: Opposition to any definition mandated by House of Delegates Resolution No. 40-76.

H.B. 267, physician exemption from jury duty on request:

ACTION: Support.

H.B. 413, hospital staff privileges bill:

ACTION: Position of opposition.

The problem of mandated insurance coverage, by insurance companies, of alcohol and mental problems was discussed.

The report of the Department, as a whole, **was approved.**

NEXT COUNCIL MEETINGS

The next meetings of the Council were set for May 19 and July 16-17, 1977.

On a motion from Dr. Gaughan, seconded by several, the Council awarded Dr. Bates a standing ovation for his outstanding service as its presiding officer.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page
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Contraindications: Nalfon is contraindicated in patients who have shown hypersensitivity to it.

Because the potential exists for cross-sensitivity to aspirin and other nonsteroidal, anti-inflammatory drugs, Nalfon should not be given to patients in whom aspirin and other nonsteroidal, anti-inflammatory drugs induce the symptoms of asthma, rhinitis, or urticaria.

Warnings: Nalfon should be given under close supervision to patients with a history of upper-gastrointestinal-tract disease and only after the Adverse Reactions section has been consulted. Gastrointestinal bleeding, sometimes severe, has been reported in patients receiving Nalfon.

In patients with active rheumatoid arthritis or osteoarthritis who also have an active peptic ulcer, attempts should be made to treat the arthritis with nonulcerogenic drugs. If Nalfon must be given, the patient should be under close supervision for signs of ulcer perforation or severe gastrointestinal bleeding.

In subacute and chronic studies in rats, Nalfon caused interstitial nephritis, glomerulonephritis, and renal papillary necrosis. These abnormalities were dose related and began to appear at doses approximating the human dose. In chronic studies in monkeys, interstitial nephritis also occurred following administration of Nalfon. Although this was seen at doses considerably above the human dose, lower doses were not studied in this species. During the course of the clinical trials, one patient developed bilateral suppurative pyelonephritis, underwent laparotomy, went on to renal failure, and died with a diagnosis of septicemia and renal papillary necrosis. It is not known whether these events were drug related. A few patients developed mild elevations of the BUN during therapy with Nalfon. Since Nalfon is eliminated primarily by the kidney, the drug should not be administered to patients with significantly impaired renal function. It is desirable to perform periodic renal function tests in all patients receiving Nalfon.

Precautions: In chronic studies in rats, high doses of Nalfon caused elevation of serum transaminase and hepatocellular hypertrophy. In clinical trials, some patients developed elevation of serum transaminase, LDH, and alkaline phosphatase which persisted for some months and usually, but not always, declined despite continuation of the drug. The significance of this is unknown. It is recommended that periodic liver function tests be performed in patients receiving Nalfon and that the drug be discontinued if abnormalities occur.

The safety of this drug in pregnancy and lactation has not been established, and its use during these events is, therefore, not recommended. Reproduction studies have been performed in rats and rabbits. When fenoprofen was given to rats during pregnancy and continued to the time of labor, parturition was prolonged. Similar results have been found with other nonsteroidal, anti-inflammatory drugs which inhibit prostaglandin synthetase.

In-vitro studies have shown that fenoprofen, because of its affinity for albumin, may displace from their binding sites other drugs which are also albumin bound and this may lead to drug interaction. Theoretically, fenoprofen, as well as other nonsteroidal, anti-inflammatory agents, could likewise be displaced. Patients receiving hydantoin, sulfonamides, or sulfonylureas should be observed for signs of toxicity to these drugs. In patients receiving coumarin-type anticoagulants, the addition of Nalfon to therapy could prolong the prothrombin time. Patients receiving both drugs should be under careful observation.

In patients receiving Nalfon® (fenoprofen calcium, Dista) and steroid concomitantly, any reduction of steroid dose should be gradual to avoid the possible complications of sudden steroid withdrawal.

Patients with initial low hemoglobin values who are receiving long-term therapy with Nalfon should have a hemoglobin determination at reasonable intervals.

Peripheral edema has been observed in some patients taking Nalfon; therefore, Nalfon should be used with caution in patients with compromised cardiac function.

Studies to date have not shown changes in the eye attributed to administration of Nalfon. However, because of adverse eye findings in animal studies with some other nonsteroidal, anti-inflammatory drugs, it is recommended that ophthalmologic studies be carried out within a reasonable period of time after chronic therapy with Nalfon has been started and at periodic intervals thereafter.

Since food decreases the blood levels of Nalfon, the drug should be given thirty minutes before or two hours after meals during the daytime.

When phenobarbital, which may enhance the metabolism of Nalfon, is added or withdrawn, dosage adjustment of Nalfon may be required.

Caution should be exercised by patients whose activities require alertness if they experience central-nervous-system side-effects from Nalfon.

Since the safety of Nalfon in patients with impaired hearing has not been established, these patients should have periodic tests of auditory function during chronic therapy with Nalfon.

Nalfon decreases platelet aggregation and may prolong bleeding time. Patients who may be adversely affected by prolongation of the bleeding time should be carefully observed when Nalfon is administered.

Adverse Reactions: *Digestive System*—The most common type of adverse reaction concerned the gastrointestinal system. Dyspepsia occurred most frequently being observed in about one out of seven patients. Other adverse reactions, in descending order of frequency, were constipation, nausea, vomiting, abdominal pain, anorexia, occult blood in the stool, diarrhea, flatulence, and dry mouth.

Three instances of peptic ulceration and/or gastrointestinal hemorrhage that may have been due to the drug and four instances in which drug relationship was questionable were observed in 3,391 individuals to whom the drug was administered for periods of time ranging up to 165 weeks.

In less than 2 percent of patients, the drug was discontinued because of adverse gastrointestinal reactions.

Skin and Appendages—The most common adverse effect was pruritus, which was seen in about one out of ten patients. Other adverse reactions were rash, increased sweating, and urticaria.

In about 1 percent of patients, Nalfon was discontinued because of an adverse effect related to the skin.

Nervous System—The most frequent adverse reaction observed was somnolence, which occurred in about one out of seven patients. Other adverse effects, which occurred less frequently, were dizziness, tremor, confusion, and insomnia.

Nalfon was discontinued in less than 0.2 percent of patients because of these side-effects.

Special Senses—The most common adverse reaction was tinnitus, which was seen in about one out of ten patients. Other reactions observed, in descending order of frequency, were blurred vision and decreased hearing.

In about 0.2 percent of patients, Nalfon was discontinued owing to adverse effects related to the special senses.

Cardiovascular—The most frequent adverse effect observed was palpitations. This was noted in about one out of twenty-five patients. Tachycardia was observed less frequently.

In less than 0.5 percent of patients, Nalfon was discontinued as a result of cardiovascular adverse reactions.

Laboratory—Anemia was noted in about one out of 500 patients. Therapy with Nalfon had to be discontinued in one patient because of anemia. Increase in alkaline phosphatase, LDH, and SGOT was observed (see Precautions).

Miscellaneous—Headache was seen in about one out of seven patients. Less frequently observed, in descending order of frequency, were nervousness, asthenia, dyspnea, peripheral edema, fatigue, malaise, and dysuria. [031677]

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The Ohio State Medical Association News

Rehabilitation Study Commission Asks for Physician Input

The Rehabilitation Study Commission, composed of eight Ohio legislators and six public members, has been formed to create a rehabilitation program in Ohio for workers hurt in industrial accidents.

The Commission is extremely interested in obtaining information from the medical profession regarding rehabilitation in Ohio and, specifically, disability determination and identification of those needing rehabilitation. The Commission has asked that interested physicians contact them by writing, calling, or appearing before the Commission. The address is 65 South Front Street, Columbus, Ohio 43215, telephone 614/466-3042.

The Commission has determined that the key to successful rehabilitation is the early identification of the people to be rehabilitated. Estimating that there are about 20,000 injured workers per year in Ohio who need rehabilitation screening, the Commission proposes development of a list of rehabilitative injuries identifiable at the time a compensation claim is filed. Workers with these injuries would be referred to a rehabilitation specialist who would discover the status of the injured worker and make a recommendation as to the type of rehabilitation program, if any, that is indicated. Once such a screening system is organized, the Commission proposes that a facilities study and a cost-benefit study be undertaken.

OSMA Executive Director Briefed by President Carter

OSMA Executive Director Hart F. Page was one of 30 members of the American Society of Association Executives Board of Directors briefed by President Carter and Vice-President Mondale at the White House on April 21, 1977. Key administration officials from the Office of Management and Budget, Federal Energy Administration, Treasury Department, and Office of Public Liaison presented details on the President's proposals dealing with energy, government reorganization, and tax reform.

President Carter said the ASAE Board, which represents millions of businessmen and women, professionals, customers, and consumers, is a "picture of America." He asked ASAE to "participate on an equal basis" with those in government trying to find solutions to the problems of energy consumption, tax reform, and welfare reform. "We need your advice, consultation, and criticism as we openly debate these controversial issues," he said.

Other White House officials that addressed the ASAE group included: Thomas (Bert) Lance, Director of the Office of Management and Budget; John O'Leary, Administrator, Federal Energy Administration; Laurence Woodworth, Assistant Treasury Secretary; and Margaret (Midge) Constanza, Assistant to the President for Public Liaison. ASAE is the voluntary membership society for more than 7,000 executives who manage leading business, professional, educational, technical, and industrial associations.

Podiatrists' Hospital Privileges

The Journal has been informed that there is confusion regarding staff membership and hospital privileges for podiatrists. The AMA House of Delegates, at the 1976 Clinical Meeting, adopted Report C of the Council on Medical Service which recommends retention of the present Joint Commission on Accreditation of Hospitals' policy regarding hospital staff membership for podiatrists. This policy states that the medical staff membership shall be limited to individuals who are fully licensed to practice medicine and, in addition, to licensed dentists.

The policy continues with a discussion of clinical privileges for podiatrists: "The governing body of the hospital, after considering the recommendations of the medical staff, may grant clinical privileges to qualified, licensed podiatrists in accordance with their training, experience and demonstrated competence and judgment."

The American Medical Association-American Podiatry Association Liaison Committee is presently identifying and developing guidelines for aiding medical staffs in assessing the competence of podiatrists applying for hospital privileges.

New Medical Publication

Perinatology/Neonatology is a new bimonthly journal published for professionals involved in the management of high-risk pregnancies and critically ill newborns. It integrates the work being done by obstetricians and gynecologists, perinatologists, neonatologists, pediatricians, respiratory therapists, nurses, and other involved specialists. Louis Gluck,M.D., Director of the Infant Special Care Nursery and Professor of Pediatrics and Reproductive Medicine at the University of California Medical Center in San Diego, will head the editorial advisory board of the journal. For further information about the publication, contact *Perinatology/Neonatology,* 825 S. Barrington Avenue, Los Angeles, California 90049.

(News continued on page 406)

News *(continued from page 405)*

OSMA Term-Life Enrollment Period

William M. Wells, M.D., OSMA President, has announced that a current enrollment is in progress for the Association-sponsored Group Term Life Insurance Plan.

The opportunity to apply for Group Term Life Insurance, at favorable rates, is one of the many advantages of membership in the OSMA. For the policy year ending August 31, 1976, participating members received a 43 percent dividend which was used to reduce their March 31, 1977 semiannual premium.

The maximum amount of life insurance coverage available for members under age 60 years is $100,000. Every policy includes accidental death and dismemberment benefits, waiver of premium during a disability, share of earned dividends, and conversion privilege. Each application is subject to underwriting approval by the insuring company.

OSMA members who wish to apply are urged to contact the plan administrator, Turner and Shepard, Inc., at 17 S. High Street, Columbus 43215, phone: 614/228-6115.

Americans Trust the AMA

According to 1976 studies conducted by the Gallup Organization, Inc., Americans trust the AMA. The Gallup Organization asked the public to rate the ethical standards of 11 professional groups and the credibility of their organizations.

In the area of believability, the AMA ranked 6.8 on a scale of 1 to 10. Other groups ranked were: news media, 6.1; business corporations, 5.0; and labor unions and federal agencies, 4.9 each.

Fifty-six percent of those responding to the survey ranked physicians "very high" or "high" in honesty and ethics. Following the medical profession were: engineers, 49 percent; college teachers, 44 percent; journalists, 33 percent; lawyers, 25 percent; building contractors, 23 percent; business executives, 20 percent; senators, 19 percent; congressmen, 14 percent; labor union leaders, 12 percent; and advertising personnel, 11 percent.

Although the public shows a high regard for physicians, a disturbingly large proportion of the population does not share this view. Physicians are held in higher esteem than the other ten occupations tested, but 44 percent of the public does not feel that physicians are highly ethical and honest.

Extension for Alien Physicians

An extension of up to one year is allowed alien physicians who entered the U.S. under certain temporary visas. This one-time extension of stay applies to nonimmigrant alien physicians who entered the U.S. prior to January 10, 1977 under a highly skilled H-1) visa, a shortage category (H-2) visa, or a continuation of medical training (H-3) visa. State-by-state licensing requirements for foreign medical graduates are detailed in an HEW report, "Foreign Medical Graduates: A Comparative Study of State Licensure Policies."

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PRECAUTIONS: As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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1. Russek HI: AM J M Sc 239:478, 1960



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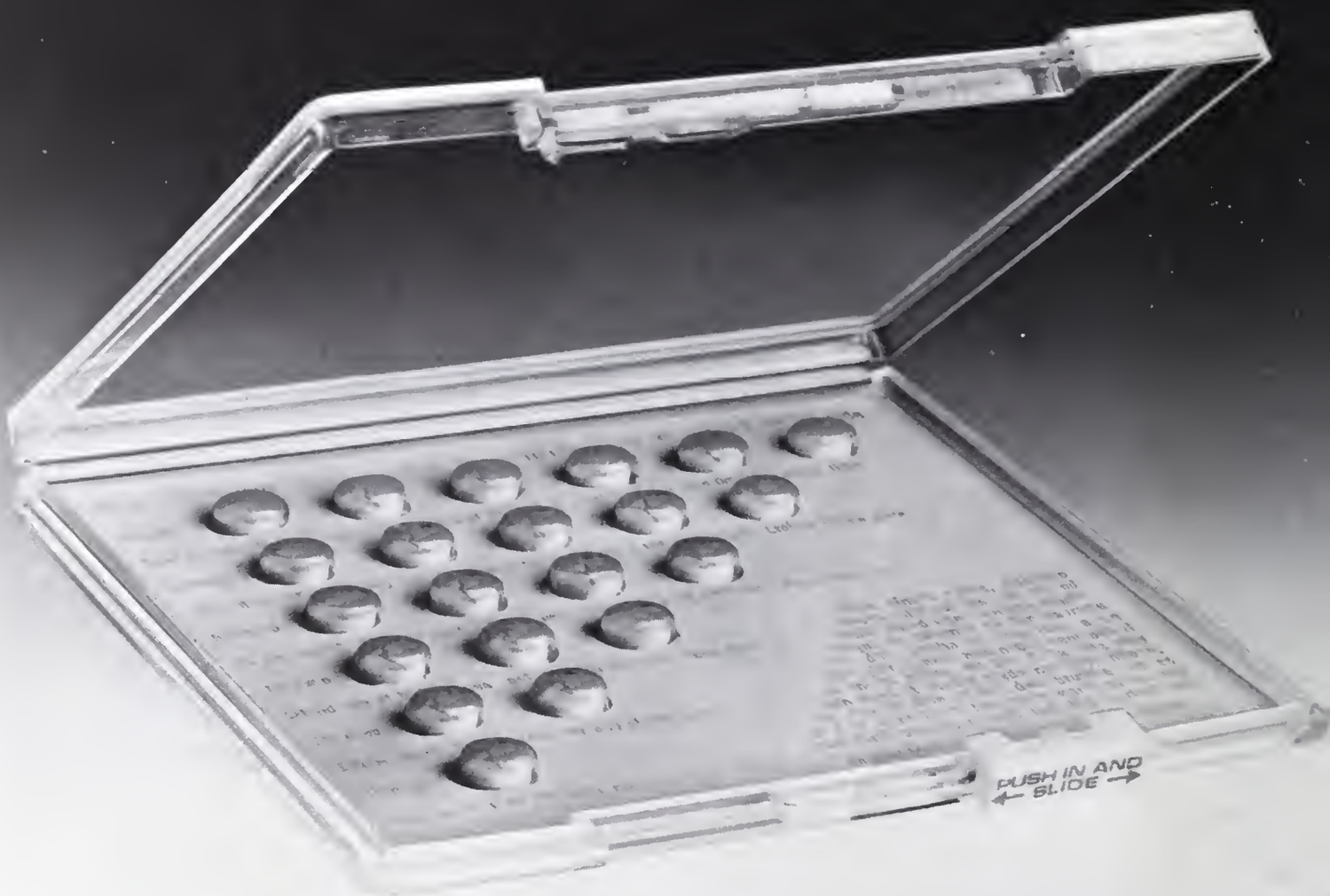
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Contributions of Cincinnati-Area Physicians To Ohio Archeology in the 19th Century

Ralph W. Dexter, Ph.D.

In 1947, Morgan and Rodabaugh traced the history of observations and explorations of Ohio mounds from the time of David Zeisberger, at Schoenbrunn, and the Reverend David Jones, along the Scioto River in 1772, to the middle of the 20th century.[1] Notable were studies of Captain Jonathan Heart in 1786; General Rufus Putnam and the Reverend Manasseh Cutler at Marietta in 1788; Dr. Daniel Drake (1815) at Cincinnati; Caleb Atwater (1820) in Central Ohio; Dr. Samuel P. Hildreth (1826, 1838) at Marietta; William Henry Harrison (1838) in the Ohio Valley; James McBride (1838) in Butler County in Southwestern Ohio; and Colonel Charles Whittlesey (1850), who studied the earthworks at Newark and Marietta in 1839 and 1840. The first extensive monograph was the classic volume by E. G. Squire and Dr. E. H. Davis in 1848.[2] Doctors Drake, Hildreth, and Davis were physicians at Cincinnati, Marietta, and Chillicothe, respectively.

After some preliminary observations on the mounds of the Little Miami Valley in Southwestern Ohio by Dr. Seldon S. Scoville,[3] Dr. Charles L. Metz discovered the Madisonville Village Site and Cemetery in 1878.[4] This event was the beginning of a long period of excavation by Dr. Metz and his co-workers. Two other physicians of the Cincinnati area, Dr. Frank W. Langdon[5] and Dr. Walter A. Dun,[6] also were engaged in such research; this article briefly reviews their contributions to the development of Ohio archeology.

Charles L. Metz, M.D.

In 1878, the Literary and Scientific Society of Madisonville was organized. It stimulated local interest in excavating mounds of the Little Miami Valley. Dr. Charles L. Metz (1847-1926) was the principal founder and investigator. He worked under the direction of Professor F. W. Putnam, Curator of the Peabody Museum of American Archaeology and Ethnology at Harvard University.[7] The work of Professor Putnam on Ohio Archeology, including his collaboration with Dr. Metz, has been published previously.[8]

Dr. Metz was the son of a physician who immigrated to this country from Alsace. Charles Louis Metz was born January 1, 1847 in a suburb of Cincinnati, where his father had a general medical practice. In 1865, at the age of 18 years, Charles entered the Miami Medical College in Cincinnati. In addition to formal medical training, his father taught him herb gardening for the preparation of medicines and, whenever possible, took him on calls to patients. Traveling far and wide on horseback in the open country on such visits, young Charles acquired a first-hand knowledge of nature and archeologic mounds; this stimulated his lifelong interest in them.

Upon receiving his M.D. degree in 1871, Dr. Metz and his bride moved to Madisonville, on the outskirts of Cincinnati, where he practiced medicine for 55 years. He was licensed to practice in 1896, when such became law, and was a member of both the Cincinnati Academy of Medicine and the Ohio State Medical Society.

In 1876, while digging in some local earthworks, Dr. Metz uncovered an earthenware vessel; this initiated a prolonged study of local Indian mounds. The Literary and Scientific Society of Madisonville was organized primarily for that purpose. Many of the meetings of the society were held in the office of Dr. Metz. Those working with him included Joseph Cox, Sr., Charles F. Low, and Dr. Frank W. Langdon.[9] The group explored especially the ancient cemetery near Madisonville. They were supported partially by the Peabody Museum of American Archaeology and Ethnology and, to a lesser extent, by the Cincinnati Society of Natural History. Most of the artifacts eventually were given to these institutions. A journal of four issues, published over a three-year period (1878-1881), summarized the early accomplishments of the Madisonville group. For the most part, the reports were reprints from the *Journal of the Cincinnati Society of Natural History* (Cox, Low, Metz, and Langdon, 1878-1881). Dr. Metz, superintendent in charge of excavations at Madisonville, published five papers and three other papers jointly authored with Doctor Langdon and Professor Putnam. Most notable of his own works are: "The Prehistoric Monuments of the Little Miami Valley" (1878) and "The Prehistoric Monuments of Anderson Township, Hamilton County, Ohio" (1881). In 1911, Metz gave a model of the Turner group of earthworks in Anderson Township to the Cincinnati Museum of Natural History which published a brief description of the model.

Frank W. Langdon, M.D.

Dr. Frank W. Langdon, born in 1853, was also a graduate (1881) of the Miami Medical College. He, likewise, was licensed to practice in 1896, established his practice in Cincinnati, and was a member of the American Medical Association. He was associated with Dr. Metz in founding the Madisonville Literary and Scientific Society and took an active part in the mound explorations. In addition to the papers he authored with Dr. Metz or other members of the group, he published three papers of his own. The most important of these was "The Madisonville Pre-historic Cemetery: Anthropological Notes" (1881) which includes measurements made on the skulls.[10]

At the annual meeting of the American Association

(continued on page 410)

Dr. Dexter, Kent, Professor of Biological Sciences, Kent State University.

Ohio Archeology *(continued)*

for the Advancement of Science (A.A.A.S.), held in Philadelphia in 1884, Professor Putnam gave a report based upon the archeologic work of Dr. Metz, who attended this meeting. Dr. Metz wrote home to his family: "The meeting is one of great success and more than 2.000 people are here.—Prof. Putnam gave me quite an ovation before the A.A.A.S. meeting today." At the A.A.A.S. meeting held in Ann Arbor, Michigan the following year, Metz and Putnam presented an "exhibition of ornaments made from pieces of human crania from a mound in Ohio." Putnam gave many lectures to various scientific groups and published a number of papers and notes on material provided by Metz and his colleagues.[8]

At the Cincinnati Centennial Exposition of 1883, Dr. Metz was awarded a silver medal for his display of archeologic specimens, and at the World's Columbian Exposition held in Chicago in 1893, he received a bronze medal for his model of Fort Hill Mound attributed to the Hopewell culture.

Walter Angus Dun, M.D.

Dr. Walter Angus Dun (1857-1877) was another physician in the Cincinnati area who excavated Ohio mounds. He was born in Madison County in 1857, and graduated from the Ohio Agricultural and Mechanical College (now the Ohio State University) with the first graduating class in 1878. Upon graduation, he studied medicine with Dr. William Carson of Cincinnati and attended the Miami Medical College from which he received his M.D. degree in 1882. Shortly before graduation, he was elected Resident at the Cincinnati Hospital; and after receiving his medical degree, he traveled and studied in Europe. In London, he studied at the University College Hospital and its physiological laboratory. Within the year, he passed examinations for Licentiate of the Royal College of Physicians and was elected a member of the Royal College of Surgeons. In 1883, be became Demonstrator of Histology at the Miami Medical College in Cincinnati and was placed in charge of Dr. Taylor's Clinic for Diseases of Children, for the summer season. Later that year, he was on the staff of visiting physicians of Children's Hospital operated by the Protestant Episcopal Church.

In addition to his medical work, Dr. Dun was an active member of the Cincinnati Society of Natural History and served as its president in 1886. He organized a Lyceum of Natural History for young people, at which he gave the first lecture which was devoted to the "early history of the earth." He donated weather instruments to the Cincinnati Society and published eight papers in its journal based on his studies of natural history and excavation of earthworks. Of the five papers published on Ohio archeology (1884-1885), the most extensive was his report on the Deercreek Mound (1884). He had a

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special interest in local archeology and was elected a Fellow of the Section on Anthropology in the American Association for the Advancement of Science in 1886. He died from an illness the following year.[11]

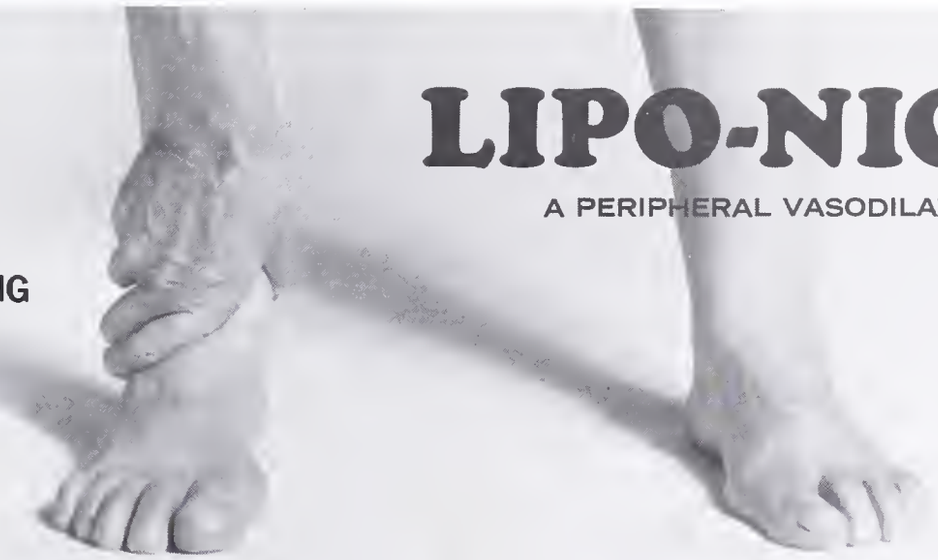
Others

In addition to those physicians engaged in excavation and publication, several were known to maintain a private cabinet of archeologic specimens. According to MacLean,[12] Dr. J.L. Kirkpatrick and Dr. J.B. Owsley, both of Butler County, had such cabinets. In 1892, Dr. Sheldon Scoville from Lebanon, returning to an earlier interest, read a paper at the Rochester, N.Y. meeting of the American Association for the Advancement of Science, based on his study of Fort Ancient. It was subsequently published in the *Journal of the Cincinnati Society of Natural History*. In a review article published in *Science* in 1897, the notable American archeologist, Dr. D.G. Brinton,[13] stated: "—there are now in Ohio 310 persons interested in its archaeology! Can any other state equal this record?" The early work of physicians in the Cincinnati area contributed much to the development of this interest during the 19th century.

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IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) .... 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) .... 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DDSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid ..... 300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) .... 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Colleagues in the News

Many Ohioans Among New Am. Board Of Family Practice Diplomates

The following Ohio physicians have become Diplomates of the American Board of Family Practice by virtue of having passed the seventh certification examination given during October 1976:

Howard Abroms, M.D.; Pacifico C. Amaro, M.D.; Dogulas R. Angerman, M.D.;

Frank M. Baldauf, M.D.; Harry M. Berley, M.D.; Walter B. Bianconi, M.D.; Henry R. Bloom, M.D.; Robert J. Blough, M.D.; James T. Bowlus, M.D.;

Luis E. Cali, M.D.; Forrest W. Calico, M.D.; Louis T. Chappell, M.D.; Joseph E. Chase, M.D.; Steven L. Cochran, M.D.; Edward J. Conrad, M.D.; Anthony J. Costa, M.D.; George M. Cotterman, M.D.;

Gerald H. Dennis, II, M.D.; Earl D. Dewitt, M.D.; Paul H. Dillahunt, M.D.;

Carol H. Estep, M.D.;

Sydney O. Fernandes, M.D., Anthony E. Foley, M.D.; Deborah K. Franley, M.D.; Alice A. Frazier, M.D.; George R. Fronista, M.D.; Harry Fronista, M.D.;

Michael E. Geron, M.D.; Gary L. Gillen, M.D.; Terrence F. Grogan, M.D.; Juan Guzman, M.D.

Charles R. Hedges, M.D.; Benjamin C. Humphrey, M.D.; Carl D. Hyde, M.D.;

Richard L. Jackson, M.D.;

Louis J. Kerth, M.D.; Theodore H. Korthals, M.D.; Joseph R. Kraynak, M.D.;

Felipe V. Lavapies, M.D.; Robert F. Lewis, M.D.; Vincent H. Linz, M.D.; Ricky L. Long, M.D.;

Christopher R. Martin, M.D.; Kayoshi Masuoka, M.D.; Margaret Miller, M.D.; Robert J. Miller, M.D.; Roy Miller, M.D.; Steven C. Miller, M.D.;

James B. Nagle, M.D.; Ferdinand J. Neihaus, Jr., M.D.;

William H. Overholzer, M.D.;

J. Joseph Payton, D.O.; Talmadge N. Porter, M.D.;

John M. Robinson, M.D.;

Frank J. Scharold, M.D.; Satish K. Seth, M.D.; Robert A. Shaw, M.D.; George Smirnoff, M.D.; Leonard K. Smith, M.D.; William T. Smith, M.D.; Ronald L. Speidel, M.D.; Gregory C. Starr, M.D.; James H. Steiner, M.D.;

Arthur A. Tesi, M.D.; Charles L. Thompson, M.D.; James B. Tucker, M.D.;

John Valassiades, M.D.; Ronald C. Van Buren, M.D.;

Elmer F. Wahl, M.D.; Anna M. Whetstone, M.D.; C. Conner White, Jr., M.D.; Thomas E. Williams, M.D.; Jay C. Williamson, M.D.; and N. Tracy Wolf, M.D.

Several Ohio physicians will receive certificates of fellowship at the 54th annual meeting of the American College of Radiology. Recipients are **FRANK BATLEY, M.D.**, Columbus; **JOHN J. GAUGHAN, M.D.**, Cleveland; **KONRAD F. KIRCHER, M.D.**, Dayton; **STANLEY J. LUCAS, M.D.**, Cincinnati; **RICHARD L. NEUBAUER, M.D.**, Cincinnati; **WILLIAM S. ROTHERMEL, M.D.**, Canton; and **CARTER R. STRAUB, M.D.**, Toledo.

SHELDON C. BINDER, M.D., has been appointed the first full-time, hospital-based Chief of Surgery at The Youngstown Hospital Association. Dr. Binder will head the surgery services at both the North and South Units of the Association as well as be responsible for the surgical residency program and for coordination of surgical training for medical students from the Northeastern Ohio Universities College of Medicine. Dr. Binder came to Youngstown from Tufts University School of Medicine, Boston, where he was Associate Professor of Surgery. He is a Fellow of the American College of Surgeons as well as a member of numerous other societies.

A. V. BLACK, M.D., Dayton, and **GREGOR SIDO, M.D.,** Toledo, participated in a medical journalism workshop conducted in Chicago by Sandoz Pharmaceuticals recently. Dr. Black is the Editor of the *Montgomery County Medical Society Bulletin* and Dr. Sido is Editor of the *Bulletin of the Academy of Medicine of Toledo and Lucas County.* Also in attendance from Ohio were Jan Armstrong, Executive Secretary of the Summit County Medical Society; Earl E. Shelton, Executive Director of the Montgomery County Medical Society; Lee F. Wealton, Executive Director of the Academy of Medicine of Toledo and Lucas County; and the Executive Editor of *The Journal,* Linda A. Jacobson.



LEFT TO RIGHT: Medical journalism workshop participants Lee F. Wealton; Gregor Sido, M.D.; and A. V. Black, M.D.

ALLAN E. BLAIR, M.D., Columbus, was one of eight physicians among the top 800 winners in the 1976 Kodak International Newspaper Snapshot Awards (KINSA). Dr. Blair, who was awarded a certificate of merit, is an oral and maxillofacial surgeon who often takes clinical slides in the operating room to use while teaching at The Ohio State University. The Kodak awards program has been conducted annually since 1935 and is channeled through the summer photography contests of participating newspapers which start in mid-May. Anyone wishing to enter KINSA in 1977 and not knowing a participating newspaper can write for details to Contest Activities Section, Corporate Information Department, Eastman Kodak Company, Rochester, New York 14650.

Dr. Blair's winning photograph appears below.



FORREST W. CALICO, M.D., Xenia, has been elected a vice president of the American College of Preventive Medicine. Dr. Calico will be responsible for the aerospace medicine division of the College.

Nine Huron Road Hospital physicians recently received the hospital's Distinguished Physician Service Award. Those honored are **A. ELIZABETH CANNON, M.D.; GEORGE IRVIN, M.D.; JACK JAFFA, M.D.; VICTOR LAUGHLIN, M.D.; IVAN LUST, M.D.; EDWARD MARSHALL, M.D.; GEORGE NELSON, M.D.; SAMUEL RESTIFO, M.D.;** and **M. P. THOMAS, M.D.**

EUNICE R. CARTER, M.D., Akron has been appointed Coordinator for Undergraduate Curriculum in Family Practice and Associate Professor of Medical Education at Northeastern Ohio Universities College of Medicine. Dr. Carter is a member of the Senior Active Staff at Akron City Hospital.

JOHN W.L. CHOW, M.D., Toledo, has been certified by the American Board of Orthopaedic Surgery.

RICHARD E. CHRISTIE, M.D., Cleveland, has been appointed Chairman of the Ambulatory Medicine Committee of the Case Western Reserve University School of Medicine. This committee is the first subject committee in Phase III of the school's curriculum. Dr. Christie is Director of the Department of Ambulatory Health Care at Saint Luke's Hospital.

A. JOHN CHRISTOFORIDIS, M.D., PH.D., Columbus, has been appointed Professor and Chairman of Radiology at the Medical College of Ohio at Toledo. Dr. Christoforidis is currently Clinical Professor of Radiology at The Ohio State University College of Medicine, where he has been a member of the faculty for more than 20 years. During an academic leave from OSU, he established the Department of Radiology and training programs in radiology at Aristotelian University in Greece. Dr. Christoforidis is a Fellow of the American College of Radiology and the American College for Chest Physicians. He holds memberships in the AMA, Association of University Radiologists, Radiological Society of North America, and American Association for the Advancement of Science.

WILLIAM CORWIN, M.D., has been honored by the Willard Area Hospital Board of Trustees for 32 years of service to the community. Dr. Corwin, who came to Willard in 1944, retired from active practice on January 1, 1977. He is a graduate of Western Reserve University Medical School.

EVA CUTRIGHT, M.D., has been named Wooster Outstanding Citizen of the Year. The first woman to receive this honor, Dr. Cutright is responsible for introducing anesthesiology to Wooster. She retired from active practice in 1964. Dr. Cutright has been active in many community groups including the American Association of University Women, the League of Women Voters, and the Planned Parenthood Program.

FREDERICK M. DAVIDORF, M.D., Gahanna, and **HENRY G. CROCI, M.D.,** Athens, have been appointed chairman and vice-chairman, respectively, of the Medical Advisory Committee of the Ohio Society for the Prevention of Blindness. They will head the Society's statewide committee which advises on medical policy related to blindness-prevention services for the public.

YOUSEF K. DEMIAN, M.D., has been elected president of the Cleveland Society of Anesthesiologists for 1977. Other officers are **THOMAS S. BRALLIAR, M.D.,** vice president; **THOMAS LAVIN, M.D.,** treasurer; **MICHELLE FUMIERE, M.D.,** secretary; and **GAETANO RONCAGLI, M.D.,** and **ROBERT WARREN, M.D.,** members of the board of directors.

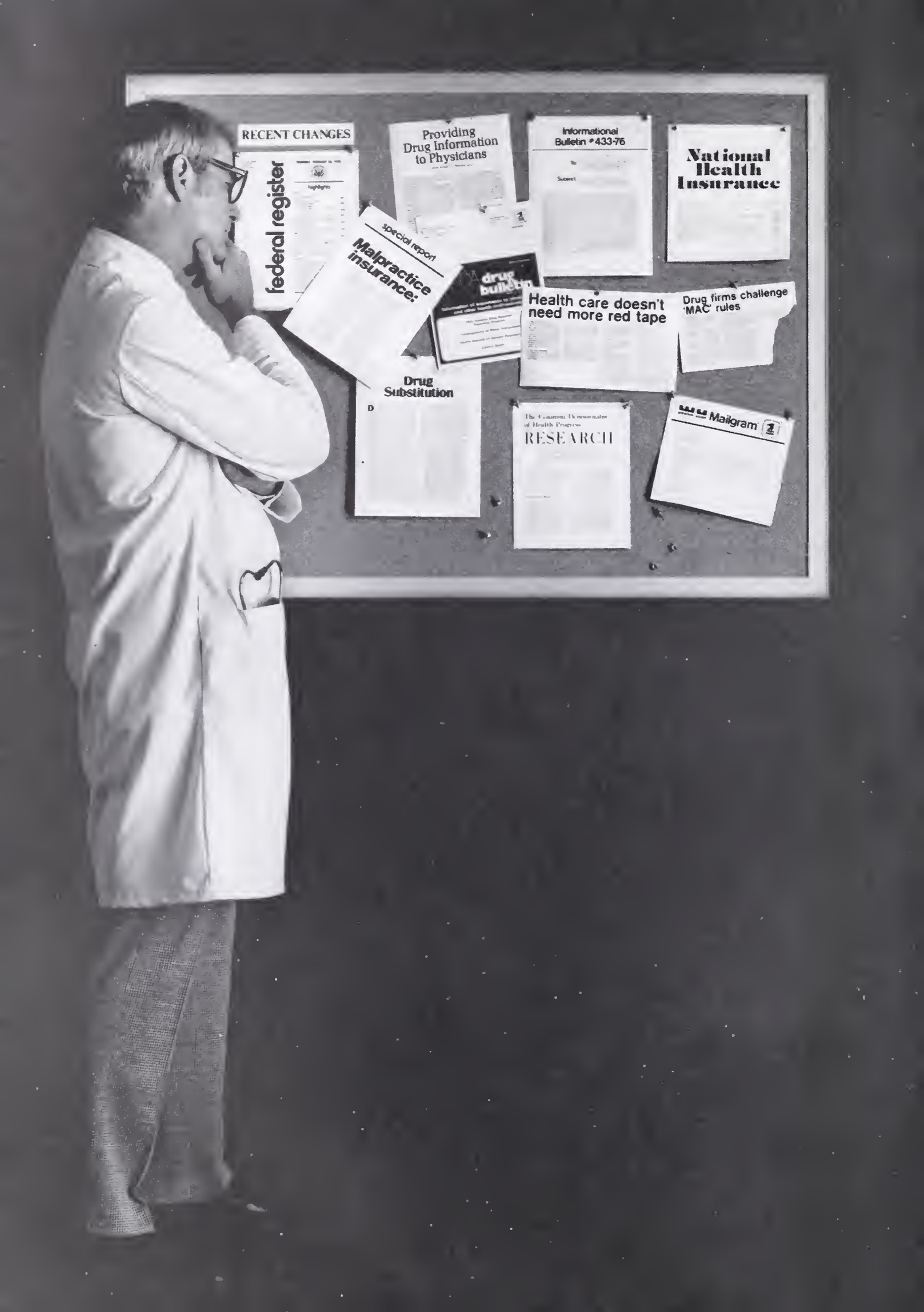
(Colleagues continued on page 416)

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RECENT CHANGES
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National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Colleagues in the News *(continued)*

RICHARD G. FARMER, M.D., Chairman of the Division of Medicine and Head of the Department of Gastroenterology at the Cleveland Clinic, has been appointed to the newly established National Commission on Digestive Diseases formed by the Secretary of Health, Education, and Welfare. Composed of physicians, scientists, and representatives of the general public, the Commission will conduct a comprehensive study of the social and economic impact of diseases of the digestive tract.

BENJAMIN FELSON, M.D., Cincinnati, has received the Gold Medal of the American College of Radiology. Dr. Felson served for 22 years as Director of the Department of Radiology at the University of Cincinnati College of Medicine. He is the author or coauthor of approximately 124 scientific papers and seven books in all phases of diagnostic radiology, but principally dealing with the radiology of disorders of the chest. In addition, Dr. Felson is a member of the editorial board of the *Journal of the American Medical Association.* A consultant for the medical corps services and major hospitals of the U.S. Defense Department, the U.S. Public Health Service, and the Veterans Administration, Dr. Felson has been listed in *Who's Who in America* since 1972.

JOHN T. FUSCALDO, M.D., Canton, has been appointed to the Medical School Committee of the Medical Staff of Aultman Hospital.

JOHN J. HALKI, M.D., PH.D., has been named Assistant Dean for Air Force Affairs, Associate Clinical Professor of Obstetrics-Gynecology, and Associate Clinical Professor of Pharmacology at Wright State University School of Medicine, Dayton. Dr. Halki is a Fellow of the American College of Obstetrics and Gynecology.

Medical staff appointments have been announced at Grant Hospital, Columbus. **EDWARD HARD, M.D.,** has been elected Chairman of the Department of Medicine; and **EUGENE MAY, M.D.,** has been elected Secretary. Appointed Chairman and Secretary of the Department of Family Practice are **WILLIAM ADRION, M.D.** and **JAMES HARDIE, M.D.,** respectively. **BOGAMIR GLAVAN, M.D.,** has been named Chairman of the Department of Emergency Medicine; and **IVAN PODOBNIKAR, M.D.,** is Chairman of the Department of Psychiatry.

HENRY J. HEIMLICH, M.D., Cincinnati, received the Sachs Award of the Cincinnati Institute of Fine Arts in recognition of his "unique and highly successful livesaving technique . . . the Heimlich maneuver." First awarded in 1929, the award has been presented to a person in the field of medicine only three times.

ROBERT A. HENDRICKS, M.D., has been elected Chief of Staff at St. Luke's Hospital, Toledo. Other officers include: **DONALD F. STEPNIEWSKI, M.D.,** Chief Elect; and **DONALD K. HARRISON, M.D.,** Secretary-Treasurer.



ARTHUR T. HOPWOOD, M.D., and **JAMES K. GIBSON, M.D.,** former superintendents of the Cambridge Mental Health and Mental Retardation Center, were honored at a recent Guernsey County Medical Society meeting for 50 years of service in the medical profession. Shown below left to right: Richard E. Hartle, M.D., OSMA Eighth District Councilor; M. W. Hnatiuk, M.D., medical director of the Center; Dr. Hopwood; State Sen. Robert T. Secrest; Dr. Gibson; State Rep. Sam Speck; Antoni Sulikowski, superintendent of the Center; and Dayle O. Snyder, M.D., medical society past president.

ARTHUR J. HORESH, M.D., Cleveland, recently received the Award of Merit from the American Congress of Allergy and Immunology. The award was given in recognition for professional achievements, contributions to the medical literature, and teaching in allergy and immunology. Dr. Horesh, past Assistant Clinical Professor of Pediatrics at Case Western Reserve University School of Medicine, was the founder of the Pediatric Allergy Clinic at University Hospitals, Cleveland, and its director for 20 years.

WILLIAM S. KISER, M.D., Cleveland, has been elected Chairman of the Board of Governors of the Cleveland Clinic. Dr. Kiser, a surgeon, will administer the medical policies of the Clinic and coordinate the activities of the Board of Governors with those of the administrative divisions. Dr. Kiser succeeds **CARL E. WASMUTH, M.D.,** as chairman.

K. WILLIAM KITZMILLER, M.D., Cincinnati, was recently made a Fellow of the American College of Physicians. Dr. Kitzmiller is Associate Clinical Professor of Dermatology at the University of Cincinnati College of Medicine and Chairman of the Section of Dermatology at Deaconess and Good Samaritan Hospitals. Currently President of the Cincinnati Dermatologic Society, he is also secretary of the dermatology departments at Christ and Jewish Hospitals and consultant to the U.S. Air Force at Wright-Patterson Air Force Base, Dayton.

MARK R. LEVINE, M.D., Cleveland, has been promoted to Assistant Clinical Professor of Ophthalmology in the School of Medicine at Case Western Reserve University. Dr. Levine is a staff member in the Division of Ophthalmology at Saint Luke's Hospital.

ALICE S. LINYEAR, M.D., Columbus, is the new Chief of the Bureau of Maternal and Child Health in the Ohio Department of Health Division of Maternal and Child Health. A specialist in obstetrics and gynecology, Dr. Linyear was a physician with the St. Louis, Missouri Health Department where she handled prenatal and family planning clinics. She also served as a family planning physician for health centers in St. Louis. Prior to these experiences, Dr. Linyear spent a year in India giving obstetrics and gynecology care.

NEVIN C. MAYER, M.D., Apple Creek, has been honored by the Wayne County Medical Society and the OSMA on the occasion of his retirement from active practice. Dr. Mayer is the oldest Wayne County physician and one of the oldest in the State of Ohio. **S. BAIRD PFAHL, M.D.,** OSMA Eleventh District Councilor; and **ERIC W. WALTER, M.D.,** President of the Wayne County Medical Society, presented Dr. Mayer a plaque.

FRANCES A. MILLER, M.D., was honored by The Youngstown Hospital Association when the Radiology Library at South Unit was named for her. Dr. Miller practiced at South Unit for 33 years before her retirement. At the time of her retirement, she was Vice-Chief of Radiology.

THOMAS J. O'GRADY, M.D., Toledo, has been elected to the Board of Trustees of Flower Hospital. Dr. O'Grady is the Immediate Past President of the Academy of Medicine of Toledo and Lucas County.

ELMER E. RAUS, M.D., D.D.S., has been elected Chief of Staff at Parma Community General Hospital. Dr. Raus has been a member of the staff since 1961 and is also Assistant Clinical Professor of Plastic Surgery at Case Western Reserve University School of Medicine. Other physicians elected to office are **JACK WISE, M.D.,** vice-president; **LOUIS KEPPLER, M.D.,** secretary; and **JOSEPH SCHULTZ, M.D.,** treasurer.

JAMES G. RAVIN, M.D., Toledo, has been certified by the American Board of Ophthalmology.

STEWART M. ROSE, M.D., Columbus, has been elected president of the Riverside Methodist Hospital Medical and Dental Staff for 1976-1977. Dr. Rose, who will also act as chairman of the Medical Council, is a cardiologist. Other officers include **KEITH DEVOE, JR., M.D.,** president-elect; **CARL R. COLEMAN, M.D.,** chairman of the Department of Surgery; and **RONALD VAN BUREN, M.D.,** chairman of the Department of Family Practice.

ROBERT N. SMITH, M.D., Toledo, received the Secretary of Defense Medal for Outstanding Public Service at a recent Pentagon ceremony. Dr. Smith, a past president of the OSMA, was sworn in as Assistant Secretary of Defense for Health Affairs in September 1976. His medal was bestowed for "initiating significant improvements in the development of policy and management techniques which are having a major impact on the delivery of health care to Department of Defense beneficiaries."



On right: **Robert N. Smith, M.D.**

JAMES T. STEPHENS, M.D., Oberlin, has recently authored a book about the Oberlin Clinic. The text, which covers the first ten years of the clinic's operation, is titled *The History of the Oberlin Clinic: An Adventure in Cooperation.*

BRUCE A. STEWART, M.D., Moreland Hills, has been elected to the Board of Governors of The Cleveland Clinic Foundation. The board, which is composed of nine physicians from the professional staff, directs medical and daily management functions of the clinic. Dr. Stewart is a member of the Department of Urology. Currently, he is President of the Cleveland Urological Society.

KENNETH S. WARREN, M.D., Cleveland, will become director of health science for the Rockefeller Foundation, New York, on July 1, 1977. Dr. Warren has been director of Case Western Reserve University School of Medicine's division of geographic medicine and is an authority on tropical diseases.

W. WALLACE WHITE, M.D., has been elected president of the Greater Cincinnati Radiological Society. Other officers are **ROGER CHARLEVILLE, M.D.,** president-elect; and **C. DAVID EVERSOLE, M.D.,** secretary-treasurer.

VICTOR M. VICTOROFF, M.D., Cleveland, has been appointed a Life Fellow of the American Psychiatric Association. Dr. Victoroff is a member of the OSMA Committee on Mental Health.

ROBERT M. ZOLLINGER, M.D., Columbus, will receive the $10,000 Dr. Rodman E. Sheen and Thomas G. Sheen Award for scientific accomplishment at the June AMA Annual Convention. Dr. Zollinger was cited for his research in gastrointestinal physiology, pancreatic pathology and endocrinology, and for his leadership in graduate surgical education at The Ohio State University College of Medicine.

THE OHIO STATE Medical Association New Members

ADAMS (Seaman)
Jose L. Basa

ALLEN (Lima)
Charles L. Thompson

BELMONT (Bellaire)
Harlan Sutandi
Myoung Kyo Yang

CLERMONT (Cincinnati)
Jimmie C. Barnes

CUYAHOGA (Cleveland)
Rowshan Z. Alavizadeh
Roger L. Black
Sheryl Buckley
Judith D'Amico
Khosrow Dorosti
Gerald Erenberg
Thomas R. Havrilla
Milton M. Lakin
Mark A. Lipton
Abdel B. Marcus
Anthony G. Pucell
Russell A. Trusso
Benjamin G. Wood

FRANKLIN (Columbus)
John C. Jump
Peter J. Utrata

FAYETTE (Washington C.H.)
Abdiel Lorente-de-la-Torre
Sarota L. Ranpura

GALLIA (Gallipolis)
Edward J. Sheridan

HANCOCK (Findlay)
Michael W. Lindamood
Leroy L. Schrodder

HURON (Norwalk)
Souheil Al Jadda
Kyung Hee Han
Yong Woong Kim

LORAIN (Lorain)
John Schaeffer

MAHONING (Youngstown)
Sheldon C. Binder
Thomas N. Detesco
Michael I. Jacobson
Steven M. Kalavsky
Choong In Lee
Murli Manohar
Hai-Shiuh Wang

MONTGOMERY (Dayton)
David M. Cathro
Anthony R. Costarella
Stephen G. England
Percy D. Mitchell, Jr.
Gary L. Nicholason
Vichit Phungrasamee
German V. Prada
Bhimavarapu K. Reddy
Noel J. Watson
Robert T. Witty

PICKAWAY (Circleville)
Primo D. Exconde

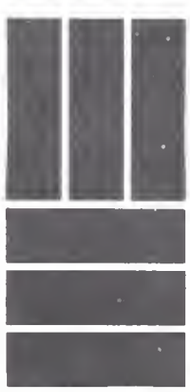
SANDUSKY (Fremont)
George M. Cotterman

STARK (Canton)
Franklin W. Griff
Alvin Langer
Milind B. Sanwardeker

SUMMIT (Akron)
Assadollah Akbari
Anand Arora
Harold W. Dietz
Richard N. Hirsh
Paul G. Koss
Leo Lutwak
Yue Pang Mok
John W. Moses
David A. Moskovitz
Rahim Salari-Lak
Phillip H. Skinner
Jan Sramka
John H. Vollman

TRUMBULL (Warren)
John W. Brady, Jr.
Keun Lyol Choi
M. Rammohan

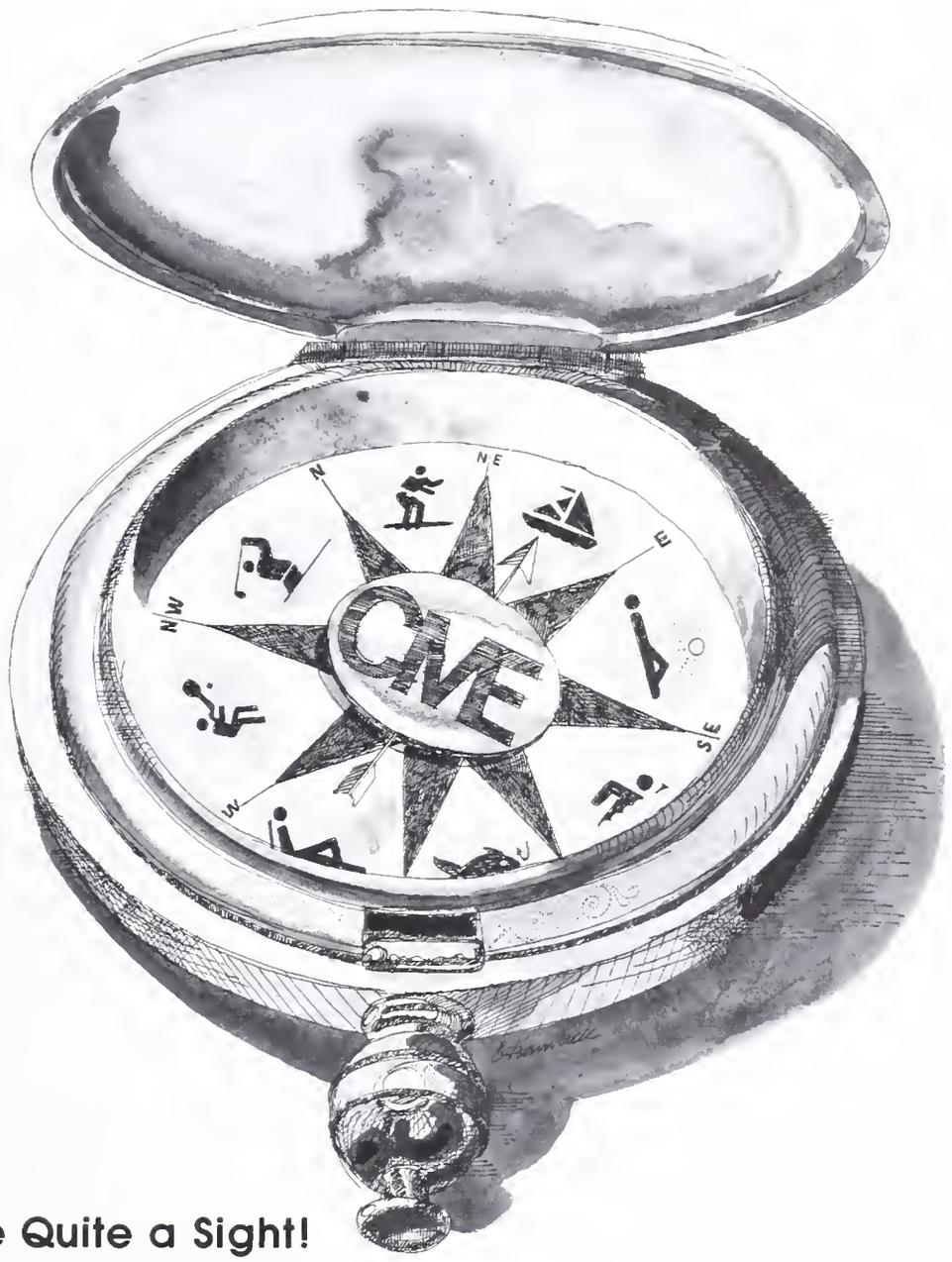
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Sept. 16-18

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Oct. 7-9

The Homestead
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Sept. 30-Oct. 2

Sheraton-Waikiki
Honolulu, Hawaii
Oct. 30-Nov. 4

FOR FURTHER INFORMATION, SEND IN THIS COUPON!

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City State/Zip _____

The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

Periodic Programs

ANESTHESIA GRAND ROUNDS: Second Thursday, each month, 4:30 PM; Miami Valley Hospital, Dayton; sponsor: Department of Anesthesiology, Wright State University School of Medicine; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

AREA-WIDE ANESTHESIA CLINICAL CONFERENCE: Dates vary; Miami Valley Hospital, Dayton; sponsor: Department of Anesthesiology, Wright State University School of Medicine; cosponsors: Miami Valley Hospital and Kettering Medical Center; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CARDIAC EVALUATION AND MANAGEMENT CONFERENCE: Second Tuesday, each month, 12 NOON; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICAL APPROACHES TO PSYCHIATRY: First Wednesday, each month, 11 AM; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICAL CONFERENCE: First Tuesday, each month, 7:30 PM; Miami Valley Hospital, Dayton; sponsor: Miami Valley Radiologic Society; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICAL CONFERENCES, DEPARTMENT OF MEDICINE: Tuesday and Thursday, each month except June, 8:30 AM; Aultman Hospital, Canton; sponsor: Aultman Hospital; 1 credit hour; contact: Dr. Gerald Smith, Aultman Hospital, Canton 44710, phone: 216/452-9911.

CLINICAL GRAND ROUNDS: Third Wednesday, each month, 8 AM; Miami Valley Hospital, Dayton; sponsor: Wright State University School of Medicine, Department of Obstetrics and Gynecology; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICAL ORTHOPEDIC CONFERENCE: First Saturday, each month, 9 AM; Miami Valley Hospital, 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICO-PATHOLOGIC CORRELATIVE CONFERENCE: First Tuesday, each month, 7 PM; Miami Valley Hospital, Dayton; sponsor: Dayton Area Pathologists; cosponsor: Miami Valley Hospital; 2 credit hours; contact: Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CLINICAL TOPICS IN PSYCHIATRY: First Wednesday, each month, 11 AM; Miami Valley Hospital, Dayton; sponsor: Neuropsychiatry Section of Montgomery County Medical Society; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

FAMILY PRACTICE GRAND ROUNDS: Second and Fourth Thursday, each month, 8 AM; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

JOINT OB-GYN AND RADIOLOGY CONFERENCE: Fourth Monday each month, NOON; Aultman Hospital, Canton; sponsor: Aultman Hospital; 1 credit hour; contact: Dr. W. Howland, Aultman Hospital, Canton 44710, phone: 216/452-9911.

MEDICAL GRAND ROUNDS: First and third Wednesday, each month, 9 AM; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

MONTHLY REVIEW OF CLINICAL ACTIVITIES OF THE DEPARTMENT OF SURGERY: Second Wednesday each month, 7 AM; Aultman Hospital, Canton; sponsor: Aultman Hospital; 1 credit hour; contact: Dr. I. F. Nikishin, Aultman Hospital, Canton 44710, phone: 216/452-9911.

OB-GYN CASE PRESENTATIONS: Third Monday each month, NOON; Aultman Hospital, Canton; sponsor: Aultman Hospital; 1 credit hour; contact: Dr. Al Langer, Aultman Hospital, Canton 44710, phone: 216/452-9911.

PERINATAL MORTALITY AND MORBIDITY CONFERENCE: First Wednesday, each month, 8 AM; Miami Valley Hospital, Dayton; sponsor: Department of Obstetrics and Gynecology, Wright State University School of Medicine; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

PULMONARY EVALUATION AND MANAGEMENT CONFERENCE: Fourth Tuesday, each month, 12 NOON; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

SURGERY GRAND ROUNDS: First Saturday, each month, 8 AM; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

SURGERY LECTURE SERIES: Every Thursday, 9 AM; Huron Road Hospital, Cleveland; sponsor: Huron Road Hospital; 1 credit hour; contact: Dr. M. D. Ram, Department of Surgery, Huron Road Hospital, Cleveland 44112, phone: 216/851-7000, ext. 265.

TUMOR BOARD: First Friday, months of June, September, and December, 12 NOON; Miami Valley Hospital, Dayton; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

TUMOR BOARD CONFERENCE: Every Wednesday, 1 PM; Good Samaritan Hospital, Cincinnati; sponsor: Office of Continuing Medical Education, Good Samaritan Hospital; 1 credit hour; contact: Joseph Preston, M.D., Pathology Department, Good Samaritan Hospital, 3217 Clifton Avenue, Cincinnati 45220, phone: 513/872-2439.

TOPICS IN CLINICAL NEUROSCIENCE: Second Thursday, each month, 7:30 PM; Miami Valley Hospital, Dayton; sponsor: Miami Valley Neuroscience Group; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

Single Course Offerings

June 1977

MEDICAL/SURGICAL GRAND ROUNDS: June 4 and 18, July 9 and 23, August 6 and 20, September 3 and 17; St. Anthony Hospital, Columbus; 1 credit hour per session; contact: Ms. Dale Nelson, 1450 Hawthorne Avenue, Columbus 43210, phone: 614/253-8877.

REYES SYNDROME: June 18, 8:30 AM; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour; contact: Sandy Bedingfield, Coordinator, Mercy Medical Center, Springfield 45501, phone: 513/399-7121, ext. 207.

TREATMENT OF BREAST CANCER: June 30; Community Medcenter Hospital, Marion; Guest Speaker: Caldwell B. Esselstyn, Jr., M.D., General Surgeon, Cleveland Clinic; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

July 1977

NUCLEAR MEDICINE FOR PHYSICIANS: July 11-15; November 14-18; Nuclear Medicine Institute, Cleveland; sponsor: Nuclear Medicine Institute; cosponsor: Hillcrest Hospital; 40 credit hours; fee: $500 ($200— residents); contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370 or 371.

OHIO VALLEY SOCIETY FOR PLASTIC AND RECONSTRUCTIVE SURGERY: July 19-22; The Inn at the Peak, Clymer, New York, sponsor: AMA; 12 credit hours; fee: $50; contact: Frank M. Tooze, M.D., 104 East 2nd Street, Erie, Pennsylvania 16507, phone: 814/455-4496.

ALCOHOLISM IN INDUSTRY: July 21; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue Marion 43302, phone: 614/383-6301.

CARE OF THE HIGH-RISK MOTHER AND INFANT: July 21, 22; Fawcett Center for Tomorrow, Columbus; sponsor: OSU College of Medicine: Departments of Obstetrics and Gynecology and Pediatrics, Ohio Department of Health, and Bureau of Maternal Child Health; cosponsor: OSU Center for Continuing Medical Education; 12 credit hours; fee: $25, Students/Physicians-in-Training—no charge; contact: Rick Panzironi, University Hospital, N-118, 410 W. 10th Avenue, Columbus 43210, phone: 614/422-7525 or 422-7526.

CHRONIC MEDICATIONS AND ANESTHESIA: July 23, 8:30 AM; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour; contact: Ernest Henson, M.D., 1343 Fountain Boulevard, Springfield 45501, phone: 513/399-7121, ext. 341.

August 1977

RAPPORT, RECORDS AND RE-EDUCATION: August 5-7; Sheraton - Columbus Hotel, Columbus; sponsor: Ohio Academy of Family Physicians; 14 credit hours; contact: Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

IMMUNOLOGY: (William F. Hughes, M.D., speaker): August 11; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Communiy Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

Where do you stand on these issues?

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☐	☐	Federal aid to medical students
☐	☐	Extending private health insurance to everyone
☐	☐	Nationwide program of community emergency medical services
☐	☐	Reform of the tort system of malpractice adjudication
☐	☐	Maximum Allowable Cost (Drug) Regulations
☐	☐	Health Planning Act of 1974
☐	☐	Federal control of the number and location of residences
☐	☐	Federal standards for licensure and relicensure
☐	☐	Federal national health service

If you're for the first five but against the second five, you stand where the AMA stands.

The AMA has vigorously supported virtually all recent legislation to provide more and better health care for the public. The AMA has just as staunchly opposed any plan that would infringe on your right to practice the way you choose.

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Classified Ads

Rates: $2.00 per line. Display classified: $4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

FOR SALE: 29′ Superior Coach Mobile Medical Clinic. Driver's area, audio and visual room, examining room, x-ray, lab with sink and toilet facilities are separate. Complete with cupboards and work counters. Carpeted. Entrance and exits with electric steps. Dodge chassis, 440 engine, AM-FM tape deck, cruise, roof and motor air, power steering and brakes. Michelins. 6,000 mi. Contact: Sheller-Globe Corporation, Toledo, Ohio, telephone: 419/255-8840.

GENERAL PRACTICE: Leaving for second career August 1st. Busy practice of 30 years, 25 miles N.W. Dayton in rich farming county, 18 other physicians, 50,000 population. In four-suite, new office building with three colleagues on night and weekend rotation call. Will accept locum tenens immediately or permanent negotiations. Call collect 513/692-8300 or 548-7010.

CLINICAL AUDIOLOGIST, M.A., ASHA certification licensed by the State of Ohio Board of Speech Pathology and Audiology, seeks position in busy ENT office. Enthusiastic worker with comprehensive range of diagnostic experience with children and adults. Reply Box 797, c/o Ohio State Medical Journal.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement of the audiologist and assumes no responsibility for the statements made.)

INTERNIST - NEPHROLOGIST: 36, ABIM, seeks quality practice opportunity within 100-mile radius of Cleveland. Currently available. Contact: Javier Clemente, M.D., 1116 Emerald Lane, Naperville, Ill. 60540, phone 312/357-0524.

FULL-TIME FACULTY MEMBERS: Division of Emergency Medicine at Ohio State University seeks full-time faculty members. Graduate of emergency medicine residency, board eligibility/certificate in surgery, internal medicine, or equivalent experience preferred. Position includes teaching responsibilities and research opportunities. New comprehensive emergency unit under construction. For further information contact Douglas A. Rund, M.D., Chief, Division of Emergency Medicine, 456 Clinic Dr., Columbus, Ohio 43215, phone 614/422-8605.

OFFICE FOR RENT OR SALE: 1820 sq. ft. In prime medical-dental office building. Three blocks from hospital. B. J. Endres, M.D., 150 Mentor Ave., Painesville, Ohio 44077, phone: 216/357-6161.

MEDICAL DIRECTOR/DIRECTOR OF PATIENT SERVICES: Fast-growing mental health center needs a Medical Director who would be responsible for supervision and coordination of all patient services, including inpatient, partial day care, and outpatient treatment. Excellent opportunity for a dynamic psychiatrist interested in community mental health and seeking a challenge. Applicants must be board certified or eligible in psychiatry and licensed to practice medicine in the State of Indiana. At least two-years' experience in a community mental health center field and/or experience working with multi-disciplinary staff is preferred. Tri-City, located in Indiana, is in the Greater Chicago area and within one-half hour's drive from downtown Chicago. Competitive salary and fringe benefits. Contact Richard E. McPherson, Center Director, Tri-City Comprehensive Community Mental Health Center, 3901 Indianapolis Boulevard, East Chicago, Indiana 46312, phone 219/398-7050.

M/F EQUAL OPPORTUNITY EMPLOYER

EXCELLENT OPPORTUNITY for doctor to build his own practice while enjoying benefits from established practice. Present work week 32 hours, no weekends, no hours outside office. Twelve years same location. Practice is about 80% bariatrics, 20% general medicine. Great potential for developing large family practice. Salary for two years, then full partnership or option to take over entire practice. $60,000 first year with vacation and bonus. Opening available now. Send resume to: H. B. Cowis, Office Manager, 112 S. Ridgeview Drive, Indianapolis, Indiana 46219.

(Classified Ads continued on page 425)

PHYSICIANS: The Ohio Department of Mental Health and Mental Retardation is seeking physicians to work in various administrative, clinical, and staff capacities in state facilities or community programs. Salaries range up to $55,000 commensurate with qualifications, education, and job requirements. An Ohio license or eligibility for a license is a requirement. For more information, submit a curriculum vitae to: Mrs. Janey Collins, Recruitment Manager, 30 E. Broad Street, Room 1155, Columbus, Ohio 43215.

G.P./INTERNIST: Needed in busy, multi-specialty clinic in suburb, 20 miles east of Cleveland, Ohio. Many fringe benefits including malpractice insurance. Negotiable first-year salary, then partnership and corporate benefits plus pension plan. Write or contact Medical Director, I. Kovacs, M.D., 38429 Lakeshore Blvd., Willoughby, Ohio 44094, phone: 216/946-9200.

MEDICAL LAB FOR SALE: Eastern suburb of Cleveland. Excellent gross, high profit, tremendous growth. Potential unlimited. Owner forced to sell for family reasons. All reasonable offers considered. Contact: The Apple Co., 1836 Euclid, Cleveland, Ohio 44115, phone: 216/621-3745.

SURGEON DESIRES a part-time position in industrial medicine, insurance exams, college health service, public health service, etc. Located in Summit, Stark, Wayne, or Medina Counties. Reply Box 798 c/o Ohio State Medical Journal.

FOR SALE: Complete eye-examination and treatment equipment, includes tonography instruments, keratometer, refracting equipment, field testing devices, and various files, cabinets, etc. Can be seen at 303 East Town Street, Columbus, Ohio, Jack R. Bontley, M.D. Call for appointment 614/224-8700.

PHYSICIANS with internal medicine, general practice, or psychiatry background and Ohio license needed for fully accredited, 800-bed institution between Cleveland and Akron. Work assignments according to interests and abilities. Good salaries and fringe benefits including hospitalization, life insurance, retirement plan, etc. Contact: Barry I. Fireman, Ph.D., Superintendent, Western Reserve Psychiatric Habilitation Center, Sagamore Road, Northfield, Ohio 44067. Phone: 216/467-7131 (Cleveland) or 216/253-4576 (Akron).

X-RAY MACHINE FOR SALE: Fischer controls. Keleket table. 100 MA unit. Darkroom accessories included. Contact: M. C. Ellison, P.O. Box 367, Peebles, Ohio 45660.

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Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
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Beltone
WHEN A HEARING AID WILL HELP

When **impotence** *due to*

androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

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WANTED: PHYSICIANS — ALL SPECIALTIES: As search consultants in the health care field, we are interested in physicians with a good career path for full-time positions as Medical Director, Assistant Medical Director, Chiefs of Clinical Departments, and clinical practice with our clients, blue-ribbon hospitals, and other organizations in the health care field. We invite your curriculum vitae so that we may contact you when the right situation develops. No financial obligation to candidate. **LEPINOT ASSOCIATES INC., 702 ABBOTT ROAD, EAST LANSING, MICHIGAN 48823.**

PEDIATRICIAN/NEONATOLOGIST: Solo or associate practice in city of 40,000. Office space, housing, and 250-bed general hospital with privileges available. (See FAMILY PRACTICE POSITION AVAILABLE ad this issue for more detailed information.) Contact: Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

THREE BOARD-CERTIFIED FAMILY PHYSICIANS looking to recruit family physician graduate or board-qualified or certified family physician as an associate in a semi-rural small town, group practice. Progressive community; local liberal arts college; excellent local community hospital; and 35 miles from Columbus, Ohio. A very good setting in which to practice, live, and raise a family. Contact Granville Medical Center, Inc., Granville, Ohio 43023, phone 614/587-0115.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third partner to practice. New facility. Excellent hospital within walking distance. (See **FAMILY PRACTICE POSITION AVAILABLE** ad this issue for more detailed information.) Contact Robert Flint, Director of Physician Recruitment, 614/382-8211 (weekdays) or 614/389-1312 (PMs or weekends), MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

EMERGENCY MEDICINE: Career opportunities available in E.D. medicine. Also short-term and locum tenens. Eight Ohio locations. Flexible work schedules and competitive remuneration. Paid malpractice, vacation, educational leave. Contact Doctor S. Spurgeon or J. W. Cooper toll-free 1-800-325-3982.

MARION, OHIO: Excellent opportunities to practice medicine. Existing and new, solo, partnership, and association. 250-bed, excellently equipped, regional-medical-center hospital; within walking distance from offices. Industry and agriculture support city/county of 65,000 and total trade area of 250,000 people. Excellent schools, 50-minute easy drive to Columbus, reliable cross coverage.

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PEDIATRICS
GENERAL SURGERY
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Seeking both rural and cosmopolitan coverage. Send CV or contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302. Phone: 614/382-8211 or 389-1312.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician who is now completing residency. Board eligible or certified mandatory. Excellent community and hospital. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 389-1312.

NEW MEDICAL BUILDING IN WEST JEFFERSON, OHIO
Three suites still available.
Space suitable for medical, surgical, and psychiatric specialties.
12 minutes— Madison Co. Hospital
20 minutes— Mt. Carmel Hospital, Columbus
J. RICHARD HURT, M.D.
JEFFERSON MEDICAL CENTER, INC.
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614/879-8141

MEDICAL DIRECTOR: Long-term facility with skilled nursing, tubercular, pediatric, chronic illness, alcoholism detox and rehab divisions. Full-time position available immediately in 199-bed J.C.A.H.-approved facility, Ohio State License required. Salary negotiable. For further information write to: Kathryn E. Shearer, Assistant Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711 or phone 216/875-5531.

(Classified Ads continued on page 426)

EMERGENCY PHYSICIAN: Columbus, Ohio. Established EM group with extensive continuing education plans needs an additional physician to improve staffing. Prefer physician who will have completed rotating internship by June 1976, with career orientation. Could accept qualified applicant for one year, July '76 - June '77. Busy EM practice in 600-bed, private teaching hospital with University affiliation (Mount Carmel Medical Center) and 250-bed private suburban hospital with 24-hour medical and surgical in-house coverage (Mount Carmel East Hospital). Must have Ohio license. At least 4 weeks vacation. Excellent starting income, meeting expenses, plus malpractice. hospitalization, disability and life insurance. Call Donald T. Evert, M.D., President, Emergency Services, Inc., 5979 E. Livingston Ave., Columbus, Ohio 43227, (614) 864-0566, 8:30 AM - 5:00 PM, Monday through Friday.

E.N.T.: Unexpected retirement has created immediate need for board-eligible or certified ENT physician. Excellent community, excellent hospital. Facilities and equipment available. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 389-1312.

EMERGENCY PHYSICIANS: Cleveland, Ohio. Opportunity to pursue career in long-established, compatible professional group providing emergency services to three hospitals in Northeast Ohio. Enjoy four weeks vacation, two weeks professional development, and a superior starting income with outstanding ancillary benefit plan. An Ohio license is prerequisite and membership in ACEP is desired. We are most interested in career-oriented individuals desirous of growth, security, and professional enhancement. If qualified and interested, please call Ronald Kimes, Group Manager, Emergency Associates, Inc. For further information and a personal interview phone: 216/461-5255, Monday through Friday, 8 AM to 5 PM.

VAIL, COLORADO, FOR RENT: Ski vacation. Days or weeks in beautiful Rockies. Spacious condominium ready for living. Fireplace, three outdoor balconies, two bedrooms and two-bed loft. Write PAM Properties, P.O. 5097, Cincinnati, Ohio 45205, or call 303/476-5532 and refer to Timberfalls 809.

MEDICAL DIRECTOR— OHIO STATE INSTITUTE FOR MENTAL RETARDATION: Opening available 7/1/77 for qualified physician full or selected-time basis. Either contract or supplemental pay scales. Salary from $45,000 and negotiable. Family practice, pediatrics, internal medicine, neurology backgrounds most acceptable. Supplemental allowances negotiable. Send curriculum vitae to Box 796, c/o Ohio State Medical Journal.

FOR SALE: Office equipment of ophthalmologist and otolaryngologist. Large, black, automatic S.M.R. chair. Thermofax copying machine. Two stainless steel E.N.T. wall cabinets with miscellaneous instruments. Stainless steel eye wall cabinet with miscellaneous instruments. Twenty stainless steel allergy syringe trays. Contact: Mrs. J. Cyril Damitz, 515 Woodside Drive, Akron, Ohio 44303. Telephone: 216/867-2324 or 376-9324.

FIND RURAL PEACE IN A COUNTRY PRACTICE: Fully equipped office and home available. Will introduce before leaving. Call 614/946-2351. R. W. Weiser, M.D., Jewett, Ohio 43986.

LOCUM TENENT needed in emergency room in Springfield, Ohio for July and August. Best hourly rate and option to join. Phone Dr. Bay 513/399-7828.

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JULY 1977
Volume 73, Number 7

THE OHIO STATE Medical Journal

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Labor Pushes Generic Bill Through House Committee

The House Judiciary Committee, in what has been called "another victory for organized labor," approved Senate Bill 45 (Freeman, D-Canton). S.B. 45 repeals Ohio's anti-substitution law. The Committee's final version of the bill permits a pharmacist to dispense a generic equivalent in place of a brand-name drug chosen by the physician. A physician can prohibit a substitution by writing on the prescription "Dispense As Written" or "D.A.W." Senate Bill 45 was promoted by the Ohio Pharmaceutical Association and received heavy support from the Ohio AFL-CIO, the Ohio Council of Retail Merchants, and the Ohio Commission on Aging.

The OSMA attempted to add an amendment permitting physicians to indicate their dispensing instructions through the use of two signature lines: one line permitting and one line prohibiting substitution. Rep. Dennis Eckart (D-Euclid) introduced the amendment despite heavy opposition from the sponsor and organized labor. The amendment failed 11 to 8. Rep. Terry Tranter (D-Cincinnati) offered a mandatory two-liner prior to Rep. Eckart's amendment. Rep. Tranter's amendment was defeated overwhelmingly, and he then lent his support to Rep. Eckart's efforts.

The OSMA was successful in clarifying and expanding the liability exemptions in the bill. This language releases physicians from liability when a pharmacist incorrectly substitutes for the named drug or when the physician does not specifically prohibit substitution. The amendment, sponsored by Rep. James Betts (R-Clevelan), received support during debate by Rep. William Batchelder (R-Medina) and Rep. Paul Leonard (D-Dayton).

Rep. Eckart sponsored a consumer amendment requiring the pharmacist to indicate "Generic Substitution Made" on the container label when a substitution is made. Rep. Batchelder sponsored an amendment that delays the effective date of the bill until January 1, 1978. Both amendments were accepted.

Senate Bill 45 has been promoted by the sponsors since its introduction as a consumer bill to save Ohio citizens money on prescription drugs. During the course of the House hearing, a number of amendments strengthening the consumer protection aspects of the legislation were defeated. The bill now goes before the Rules Committee to be scheduled for a floor vote.

OSMA members are encouraged to contact their local state representatives, informing the legislators of their opinions regarding S.B. 45 and the importance of physician control of drug therapy.

Physical Therapy Bill Approved by House

House Bill 209 (Rankin, D-Cincinnati), legislation altering the definition of physical therapy and removing the regulation of physical therapists from the State Medical Board to a combined occupational therapy-physical therapy board, was overwhelmingly approved by the House. Amendments adopted in subcommittee removed most of the OSMA objections to the bill. The OSMA Department of State Legislation received a great deal of assistance in the subcommittee from three Columbus-area physicians: James Powers, M.D.; George Waylonis, M.D.; and Claire Wolfe, M.D.

The physical therapy legislation contained language permitting physical therapists to conduct electromyograms. This language was removed and was replaced with existing statutory language. (The State Medical Board has ruled electromyography to be the practice of medicine.)

The OSMA maintains a position of opposition to the creation of a combined board; but if the Legislature deems that a combined board is proper, H.B. 209 now contains language that requires a physician be a full, voting member of the physical therapy section of the board.

A provision still remains in the bill that prohibits a physician or someone under the supervision of a physician from designating his office services as "physical therapy," but does not prohibit the physician or someone supervised by the physician from performing such procedures. The bill now goes to the Senate for further consideration.

OSMA Opposes Use of Diagnostic Drugs by Optometrists

The Senate Education and Health Subcommittee is examining Senate Bill 163 (Jackson, D-Cleveland). This legislation proposes that optometrists be permitted to use "diagnostic drugs" as well as greatly expands the definition of optometry. The OSMA and the Ohio Ophthalmological Society strongly oppose S.B. 163.

The Ohio Optometric Association legislation creates a "Diagnostic Pharmaceutical Agent's License" to be issued by the State Board of Optometry after an optometrist completes a course in ocular pharmacology and passes an examination administered by the Board. The Optometric Association representatives have told the subcommittee members, Senators Marcus Roberto (D-Ravenna), John Mahoney (D-Springfield), and Ben Gaeth, (R-Defiance), that a great service would be provided to the citizens of Ohio if optometrists were permitted to use "diagnostic drugs."

The OSMA Department of State Legislation and Ohio Ophthalmological Society testimony has focused on the potential problems resulting from an optometrist's use of "diagnostic drugs" and the difficulty in diagnosing and interpreting any physical problem. The great difference in the training between medical doctors and optometrists significantly affects the optometrist's ability to cope with emergencies resulting from the use of drugs in a patient's eye.

Optometrists have said the use of "diagnostic drugs" would better enable them to screen patients for eye dis-

(continued on page 428)

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the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Administration's Program for Hospital Cost Containment Under Consideration by House

The House has moved swiftly to consider the Administration's sweeping hospital cost containment program that has drawn the wrath of hospitals and physicians. Joint hearings by the Health Subcommittees of the House Ways and Means and House Commerce Committees are in progress. Divising a bill, however, will take a long time and it could look much different than what the Administration is asking.

Rep. Paul Rogers (D-Fla.), Chairman of the Commerce Health Subcommittee, said in introducing the Administration's bill: "we must proceed with care in this area." The influential lawmaker questioned whether "any system for controlling the increases in costs of hospital care will work over the long run unless . . . an incentive system is present" to encourage hospitals to hold down increases.

Rep. Dan Rostenkowski (D-Ill.), Chairman of the Ways and Means Health Panel who also dropped the bill in the hopper, told the House: "I am sure there will be serious objections raised to the President's proposal. Some will argue that a cost containment program applying only to hospitals unfairly singles them out and will do harm to the quality and availability of necessary care."

The House hearings so far have met an almost solid block of opposition from health providers as well as tepid endorsement from labor.

Even more foreboding from the Administration's standpoint is the fact that no member of the health subcommittees of the House Ways and Means and House Commerce Committees took the role of all-out champion of the Administration proposal during the three days of joint hearings. Some lawmakers directed criticism at hospitals and physicians in connection with the inflation in health care costs, but none of the Congressmen seemed enamored of the Administration's scheme for dealing with the problem.

The American Medical Association told the subcommittees the legislation singles out one segment in the economy for the imposition of special controls by limiting inpatient revenues of most hospitals to approximately a 9 percent increase annually. This legislation is similar to the "opprobrious retention" of the "now discredited" wage-price controls to the health field in Phase IV of the economic stabilization program while removing controls from the rest of the economy, according to Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees.

"The AMA is concerned over the impact that this legislation would have on the quality and availability of hospital care for the American people," said Dr. Holden. "It seems inescapable to us that the 'cap' on spending will result in second-rate care, and some care may simply become unavailable for many people."

The American Hospital Association, the Federation of American Hospitals, the American Protestant Hospital Association, the Catholic Hospital Association, and the Association of American Medical Colleges were among other health organizations that weighed against the Administration plan. The Health Insurance Association of America gave "somewhat qualified support" with many reservations. The Blue Cross Association proposed a national moratorium on new plant capital expenditures, but said "we seriously question" whether the cap plan would be "effective or equitable."

Thrust of the testimony of the AFL-CIO and the United Auto Workers was that the wage increase "pass through" was inadequate and that a better approach would be to adopt the labor-backed national health insurance plan, the Health Security Act.

The State Scene *(continued)*

ease. Physicians have stressed that the screening for eye disease for the purpose of referral does not require the use of drugs. Ten states have rejected this type of legislation recently.

Physicians should contact their local senators and the members of the Senate Education and Health Committee (See Vol. 73, No. 6, June 1977, issue of *The Journal,* page 357, for list of Committee members.) to inform them of the danger of nonmedical practitioners using topical agents which have both local and systemic side-effects. Members of the Committee and the Senate need to know that most physicians routinely examine their patients' eyes because the eye is an integral part of the body which can be properly examined only by someone with a medical education. Contact the OSMA Department of State Legislation or local ophthalmologists for further information regarding Senate Bill 163.

Laetrile Bill Passes Committee

The House Health and Retirement Committee approved House Bill 650 (Sweeney, D-Cleveland) by a two-vote margin. This legislation legalizes the manufacture, distribution, and sale of Laetrile (amygdalin) in the State of Ohio. H.B. 650 permits Laetrile to be sold over the counter except when the substance is intended for injection, which requires a physician's prescription. Rep. Richard Finan (R-Cincinnati) sponsored an amendment to permit Laetrile in injectable dosages to be sold over the counter. The amendment, consistant with OSMA policy, was defeated by one vote.

H.B. 650 contains an informed request form the prescribing physician provides the patient before prescribing an injectable dosage of Laetrile. The patient must sign the form indicating that he has been made aware of alternative, recognized treatments for the disease and voluntarily has chosen Laetrile. An amendment was included in H.B. 650 by Rep. Donald Maddux (D-Lancaster) and Rep. Ronald James (D-Proctorville) requireing all containers of Laetrile to carry the words: "Amygdalin is not recommended by the Ohio State Medical Association for the treatment of cancer. Amygdalin may be harmful to your health." The bill now goes before the Rules Committee to be scheduled for a floor vote.

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COVER: OSMA President George N. Bates, M.D., Toledo, presided over the sessions of the House of Delegates at the 1977 OSMA Annual Meeting. At the conclusion of the final session, William M. Wells, M.D., Newark, was sworn in as President of the Ohio State Medical Association. Elected President-Elect of the Association was John J. Gaughan, M.D., Cleveland. A full report on the actions of the OSMA House of Delegates begins on page 467 of this issue.

The Ohio State Medical Association Proceedings of the Council

The Council of the Ohio State Medical Association met at 8:30 AM, May 19, 1977 at the Sheraton-Columbus Hotel.

Those present were: All members of the Council (with the exception of Theodore J. Castele, M.D.); James E. Pohlman, Esq., OSMA Legal Counsel; and Messrs. Edgar, Gillen, Campbell, Clinger, Holcomb, Mulgrew, Ayish, Torrens, Mrs. Dodson, Mrs. Wisse, Ms. Doll, Mrs. Jacobson and Mrs. Franklin of the OSMA Staff.

The President introduced Stewart B. Dunsker, M.D., Cincinnati, newly elected Councilor from the First District.

Dr. Bates expressed his appreciation to all and especially to Mrs. Dodson and Mr. Torrens for their efforts on the success of the 1977 Annual Meeting.

STANDING AND SPECIAL COMMITTEES

Listings of the Standing and Special Committee appointments for 1977-1978 were distributed. Dr. Wells stated he would not call for approval of these appointments until the next meeting of the Council inasmuch as House of Delegates' action will require additions to the Standing Committees. He asked the Councilors to send to him suggestions for appointments to the committees.

AUXILIARY REQUEST

The Council considered a request from the Ohio State Medical Association Auxiliary (OSMAA) for assistance in efforts to be the number one state in AMA-ERF contributions. After discussion, **a motion was made and carried,** advancing $3,000 to the OSMAA and that component medical societies be asked to share in this contribution. It was asked that a progress report be given at the next Council meeting.

CINCINNATI MATTER

Dr. Dunsker discussed a situation in Cincinnati that is receiving considerable media attention wherein methods

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used by the County Prosecutor's office in investigating and obtaining medical records of a physician under investigation by the Ohio Department of Public Welfare were highly questionable.

It was the consensus of the Council that Legal Counsel seek additional information regarding this matter and that objection be made in an appropriate manner regarding the methods employed in this investigation.

COUNCIL MEETINGS

Dr. Wells announced the next meeting of the Council would be in the OSMA Offices on July 9-10, 1977. Several Councilors indicated conflicts with the announced date for Council "think session." The date for the "think session" was changed to October 27-29, 1977.

Dr. Wells asked Councilors and staff to send to him written suggestions for improving Council meetings.

Dr. Williams announced that John H. Budd, M.D., AMA President-Elect, would be the Convocation Speaker at the OSU College of Medicine on July 10, 1977.

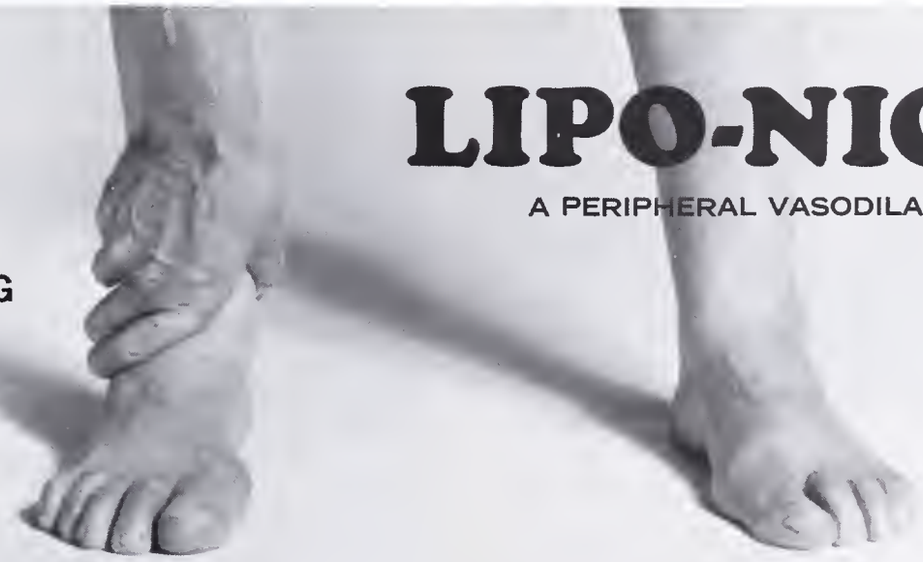
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LEFT TO RIGHT: OSMA Director of Continuing Medical Education Gail E. Dodson and OSMA Committee on Scientific Work Chairman John E. Albers, M.D.

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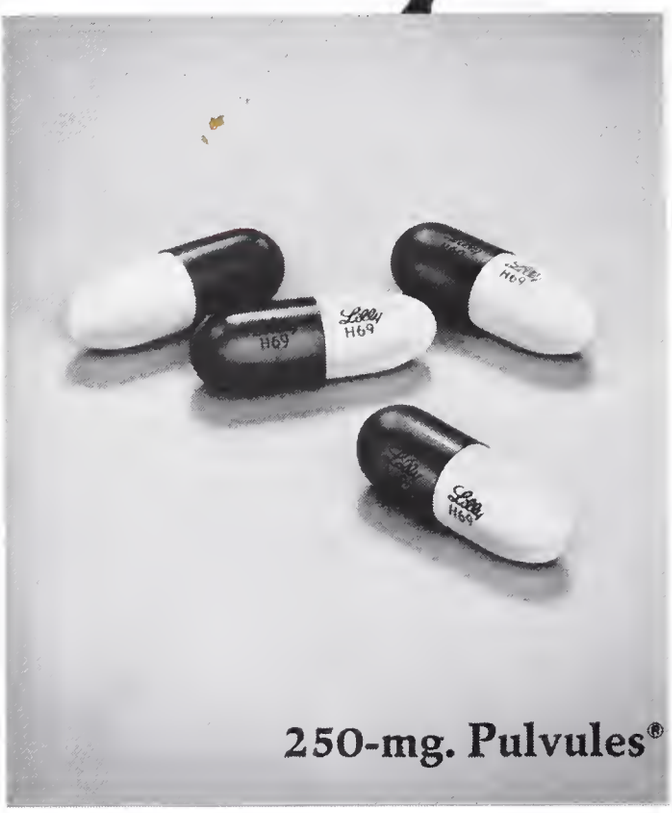
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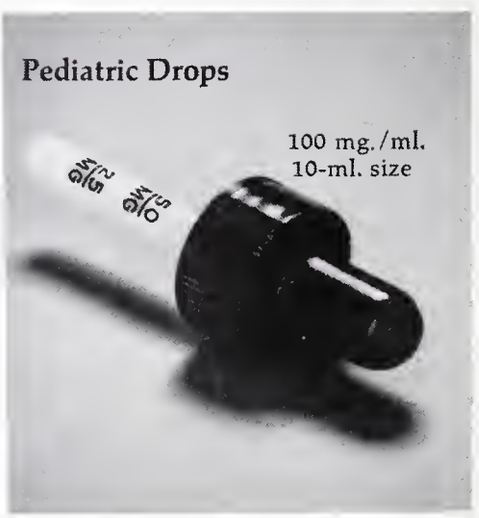
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Esophageal Neoplasms

A Ten-Year Survey at a Veterans Administration Hospital

Emil Gutman, M.D.

A ten-year clinical review was undertaken to compare treatment regime with survival time of patients with the diagnosis of esophageal neoplasm. During the period of this study, 70 patients with this disease entity were treated at the Veterans Administration Hospital, Dayton, Ohio. Only one of the neoplasms was found to be a benign tumor (leiomyoma). Overall survival after a positive diagnosis of malignancy was made ranged from two days to more than two years. Patients treated only with surgery had an average survival rate of four months and 19 days; colon by-pass cases survived an average of four months and 19 days; those who had esophagogastrectamy had a survival average of eight months and 25 days. The patients treated with irradiation alone had the longest survival, an average of nine months and 7 days.

WE WOULD NOT BE AMISS to take time out from our daily routine and take stock of ourselves occasionally. Scientists, physicians, and others concerned can be proud of such accomplishments as the discovery of the polio vaccine, the development of antibiotics and tranquilizers in the past decades, and the recent development of highly sophisticated diagnostic and therapeutic tools and methods.

Yet there still remain areas in which progress is painfully slow and the results leave much to be desired. Such is the case of neoplasms of the esophagus which are usually malignant, except for a small number of benign leiomyomas.[1] Although reports vary, prognosis and survival rates generally are poor.[2-5]

Clinical Data

This series, covering the ten-year period ending December 31, 1970, includes all patients admitted to the Veterans Administration Hospital, Dayton, Ohio, with the diagnosis of esophageal neoplasm. Of a total of 70 cases diagnosed as esophageal neoplasm, one benign tumor (leiomyoma) was successfully removed surgically. Squamous cell carcinoma was proved by biopsy in 35 cases and by cell studies in one case. Results of seven biopsies were negative; two revealed carcinoma in situ, and one showed inflammatory cells with repeat study suggested. An anaplastic neck node was found in one case. Biopsy was not done in 19 cases, and nine patients previously diagnosed were received as transfers from other hospitals. Diagnosis was made at autopsy in two cases. Excluding the case of the benign tumor, the mortality was 100 percent for the ten-year period.

Survival after a positive diagnosis was made ranged from two days to more than two years (Table 1).

Treatment was palliative in eight cases, surgical in 21 cases, irradiation therapy in 24 cases, no treatment in 15 cases, and treatment not specified in two cases. Four cases had a combination of surgery and irradiation therapy

Ages ranged from 36 to 86 years, with an average age of 62 years for the complete series (average of 58.0 years for 27 black patients and 64.7 years for 24 white patients).

Time elapsed from onset of symptoms until admission to the hospital varied from less than one month to

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Submitted October 26, 1976.

over 18 months, with the largest number in the one-to-six-month group (Table 2).

As might be anticipated, the two most frequently encountered symptoms were dysphagia and weight loss, usually but not invariably present in combination. Less frequently reported symptoms were weakness usually accompanied by anorexia, pain, and epigastric distress (Table 3). Dysphagia varied from a two-day duration to two years, but the majority of cases ranged from several weeks to less than one year (Table 4). Weight loss was difficult to document accurately; it was noted without specific amounts in ten cases. In other cases, the weight loss was recorded from a low of 10 lb (over an unspecified time) to a high of 60 lb in a six-month period.

There were nine cases in this series in which it was not known if examination by esophagram was done and, if so, what the findings were. These were cases transferred from other hospitals. Esophagram was not done in ten cases, and was attempted but unsuccessful in two cases. Of the 48 esophagrams documented, 39 showed evidence indicating or suggesting malignant neoplasm; two were not conclusive; four were interpreted as stricture; the impression was of esophagitis in one, large varices in one; and no lesion was found in one case.

Except for three cases diagnosed at autopsy and one carcinoma in situ diagnosed by biopsy, the extent of the lesions in this series ranged from 3½ cm to over 9 cm. We could find no definite correlation between the symptoms either in relation to the location or to the extent of the disease. For example, one patient, whose only symptoms were dysphagia and weakness for one month, had a colon by-pass and survived five months and 6 days. Yet another had dysphagia for one year, had a 50-lb weight loss, was treated by both cobalt irradiation and surgery, and survived three months and 5 days following admission. In general, about 15 percent of the cases had proximal lesions, mean survival time was four months and 17.3 days; 40 percent of the cases were lesions in the midesophagus with average survival of five months and 2.1 days; 45 percent were in the distal esophagus with survival of ten months and 2.4 days.

The following proved the diagnosis in all but two of the nine cases whose biopsy results were negative:

1. Positive esophagram and esophagogastrectomy.
2. Esophagram suspicious of carcinoma; cell studies

Table 1. Survival Time After Positive Diagnosis (51 Cases)

Months	No. of Cases	Percent
Less than 1	8	15.68
1 to 2	5	9.80
2 to 3	7	13.70
3 to 4	7	13.70
4 to 5	2	3.90
5 to 6	3	5.88
6 to 7	2	3.90
7 to 8	1	1.96
8 to 9	3	5.88
9 to 10	5	9.80
10 to 11	3	5.88
11 to 12	0	0.0
12 to 13	1	1.96
16	1	1.96
19	1	1.96
20	1	1.96
28	1	1.96

Table 2. Onset of Symptoms Prior to Admission to Hospital

Months	No. of Cases	Percent
Less than 1	6	8.7
1 to 6	31	44.9
6 to 12	12	17.4
12 to 18	1	1.4
Over 18	1	1.4
Unknown or no symptoms	18	26.0

Table 3. Symptoms Reported on Admission to Hospital

Symptom	No. of Cases	Percent
Dysphagia	50	54.9
Weight loss	29	31.9
Weakness and/or anorexia	6	6.5
Pain	4	4.4
Epigastric distress	2	2.2

Table 4. Duration of Dysphagia

Months	No. of Cases	Percent
1	11	22
2	3	6
3	5	10
4	3	6
5	1	2
6	5	10
7	0	0
8	1	2
9	1	2
10	1	2
11	0	0
12	3	6
14	1	2
Unknown	15	30

Table 5. Types of Treatment

Treatment	No. of Cases
Palliative	8
Surgery	21
Irradiation	24
None	15
Not specified	2

positive for squamous cell carcinoma.

3. Carcinoma found on esophagram, patient survived two days less than 10 months.

4. Esophagram showed carcinoma; distal one-third resection with esophagogastrectomy was done.

5. Carcinoma of larynx with spread to cervical esophagus.

6. Unproven lesion, therapy by medications only. Patient had dysphagia for six months and a 25-lb weight loss in 24 months.

7. Diagnosis made at an outside hospital; surgical transplant of colon.

8. Annular carcinoma shown on esophagram.

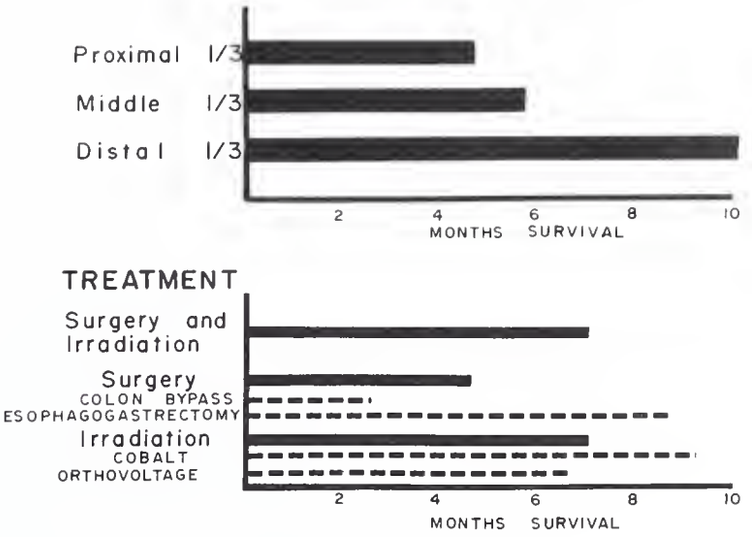
9. Obstructive tumor distal to esophagus; patient died from pulmonary infarction and effusion.

Esophagogastrectomy was performed in two cases (one with splenectomy), colon replacement or by-pass in four cases, and Celestin's tube inserted in one case. Surgery and irradiation therapy in three cases resulted in a survival time ranging from three months and 4 days to nine months and 12 days, an average of seven months and 6 days.

Cases treated by surgery alone showed an average survival of four months and 19 days, with a range from four days to nine months and 2 days. Colon by-pass cases averaged four months and 19 days survival, with a range of four days to eight months and 7 days. Average survival for esophagogastrectomy cases was eight months and 25 days, with a range of eight months and 18 days to nine months and 2 days. (See Figure.)

Survival averaged seven months and 8.4 days, with a range of two months and 3 days to 29 months and 24 days in cases treated by irradiation alone. Since a significant number of these cases received irradiation treatments at other hospitals and later were transferred to us, we were unable to obtain accurate statistics as to field size. In all except two cases, tumor dose was 5,000 rad or more and in two cases, orthovoltage with grid was used to deliver 9,000 rad (survival five months and 28 days) and 13,000 rad in each of two portals (survival four months and 3 days).

Orthovoltage yielded an average survival of six months and 24 days, while cobalt therapy resulted in average survival of nine months and 7 days.



Survival Time by Treatment Site

Summary

In this series, survival time was the longest in the cases of lesion of the distal esophagus that were treated by irradiation alone. However, average time for cases receiving irradiation therapy exceeded that for combined surgery and irradiation by only two days. Survival was longer with esophagogastrectomy than with colon by-pass.

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Health Care Costs of Gunshot Wounds

Madhira D. Ram, M.D., Ph.D.
Juan J. Geldres, M.D.
Jose B. Bueno, M.D.

Victims of gunshot wounds form a significant percentage of patients treated at urban hospitals. The costs of health care involved in treating these patients were studied at a teaching hospital in a large metropolitan city. During a four-month period in 1974, forty-one victims of gunshot wounds were seen at this institution. Twenty-three of them were admitted to the hospital and 15 were operated on. The mortality rate for the entire group was 20 percent. Operative procedures performed included major surgery on most of the abdominal viscera, craniotomy, lobectomy, thoracotomy, and surgery on the extremities. It appears that, at this institution alone, annual costs for treating gunshot wound victims were about a quarter of a million dollars. Projected on a citywide basis, they extend to $1½ million. Treating these wounds places great demands on surgical facilities and related units.

Gunshot wounds are a rapidly growing, malignant disease, but they are preventable. Surgeons, all health personnel, and the public should understand the problems associated with the use of firearms, the related demands on health care, and should work toward their prevention.

CIVIL VIOLENCE is many sided with an almost unlimited number of varieties and causative factors.[1-3] The number of offenses in group violence and individual acts of violence in which firearms have been used has increased throughout the world.[4] In the United States, there has been a malignant growth of the crime rate in the last decade. The problem with violence not only is what *causes* it, but also the *effects* it produces.

As a result of violent crimes, many people are injured; the majority of them require medical treatment. The effects of the crime may extend from psychologic shock at one extreme to death at the other end of the spectrum. Violent death instinctively arouses public horror, but the impact of it dissipates quickly. The victim's family suffers a permanent loss and the victim becomes a statistical entry in a government document. On the other hand, those that are injured and endure hospitalization and treatment not only live through the horror of the violence but also may suffer permanent disability and financial losses. Whether they are innocent or otherwise, these people end up with huge medical bills, often lose their jobs, and amass large debts. Unfortunately, this tragic aspect of the problem has received very little attention.

In the United States, a majority of civilian crimes are inflicted by the use of firearms. Unfortunately for the victim, injuries produced by firearms are much worse than those inflicted by sharp or blunt instruments. Currently, the costs of health care are being discussed from many aspects. It is important to note how much gunshot wounds are costing society in terms of health care. The impact of gunshot wounds on the health care system also will be a further argument to reinforce the need for some form of restriction on the availability of handguns. This paper is a study of victims of gunshot injuries treated at a major hospital in the city of Cleveland. It reports on the nature of injuries, surgical procedures performed, the utilization of hospital services, and the costs of health care involved in treatment of these patients.

Materials and Methods

Patients in this study included all victims of gunshot wounds who were brought to the emergency room of the hospital during the four-month period from July through October 1974. These four months were chosen as representative of the year; they include two peak-incidence months (July and August) and two other representative months.[5] The care of the patients was documented from the time they arrived at the emergency room until they were discharged from the hospital or died during their course of hospitalization. The nature of injuries sustained, number of surgical procedures per-

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Submitted October 20, 1976.

formed, use of other hospital facilities, including blood transfusions, intensive care, radiology, and the outcome of such therapy was documented. In terms of health care costs, we obtained the data based on hospital care, surgeons' fees, fees for anesthesia, and radiology services. Based on the data derived from this sample, we have estimated the annual costs for treatment of such victims at our hospital and in the city of Cleveland.

Results

During the four-month period, a total of 41 patients who sustained gunshot wounds were brought to the emergency room. Thirty-nine of the victims were shot with a handgun. Four of them were dead on arrival at the emergency room; 23 were admitted to the hospital for treatment; 14 patients had injuries not necessitating hospital admission and were treated as outpatients. Of the 23 patients admitted, 15 had surgical procedures performed on them. Four of the 23 patients admitted died later in the hospital.

Sites of Injuries

The distribution of sites of injuries showed that the abdomen was the most frequent site of injury; it was involved in eight of the cases. The head was injured in six patients, extremities in five, chest injuries in two, and spinal cord injury in two. In the group of eight patients with abdominal injuries, the most frequent viscera injured were the liver and colon — four patients each. The major abdominal vessels were injured in three patients; the kidneys, pancreas, and stomach in two each; and the gallbladder in one patient.

Surgical Procedures Performed

Fifteen of the 23 patients admitted required surgical treatment which included: suture of major blood vessels in six instances, suture of liver laceration, cholecystectomy, suture of pancreatic laceration, and suture of perforated stomach in two patients each, gastrojejunostomy and bowel resection in one patient each. Of the other patients, the following procedures were performed on one patient in each instance: craniotomy and lobectomy, open reduction of fractured long bones, laminectomy, thoracotomy, and nephrectomy.

Use of Hospital Facilities

The 23 patients admitted accounted for a total of 315 days in the hospital, an average of 13.6 days per patient. Of the total days in the hospital, 83 were spent in the intensive care unit, an average of 3.6 days per patient in intensive care. One hundred units of blood were transfused to these patients for an average of 4.3 units per patient. The average blood requirement at our hospital during a seven-day period is 90 units.

Cost of Health Care

The total cost of hospital care, surgeons' fees, anesthesia, and radiology services was $71,937 for an average of $3,127.70 per patient. The projected annual charges at this hospital for a year were approximately $220,000, details of which are shown in the Table. Almost 40 percent of the total costs incurred never were recovered.

Discussion

Violence can be considered as a malignant disease of the human society. It has been estimated that, in the past 5,000 years of recorded human history, there were only 297 years of peace and a total of 14,533 wars. It shows that, in spite of a professed desire of the human being for peace, it is a dream rather than a reality.[3] Crimes are the result of group or individual acts of violence. Forms and magnitude of each one vary greatly according to the nature and character of each society.[1] Collective group violence is of a political type mostly. It takes place in societies undergoing transition and occurs in the United States infrequently. In contrast, individual acts of violence are more frequent in a modern industrial society. American society in general — with its high crime rate and great accumulation of social tensions — is much more violent than other countries of the world.[6] In 1973, there were 19,510 murders committed in the United States, which represents an increase of 4.5 percent over the murders in 1972, and 34.8 percent increase over the figures for 1968.[7] There are many contributory factors to this high incidence of murder, but according to Jett et al,[5] the most significant contributary factor appears to be the ready availability of firearms and an unbelievable willingness to use them for terminating disagreement. These disagreements often are of a domestic nature, and the use of violence occurs during emotional arguments.

At present, there are more firearms in homes in the United States than at any previous time. It has been estimated that the arsenal of privately owned guns in Atlanta, which has a high homicide rate, would provide approximately two weapons for every man, woman, and child in that city.[8]

A number of arguments could be advanced for the control of firearms in civilized society. Proponents and opponents have argued this issue in the lay press and in the legislatures. It should be pointed out that in this advanced and civilized society, where many preventable diseases, such as poliomyelitis, diphtheria, and small pox,

Costs of Health Care for Gunshot Wounds
Huron Road Hospital, Cleveland, Ohio

Charge	Four-Month Period	Projected Annual Charges
Hospital care	$52,284	$156,852
Surgeons' fees	13,800	41,400
Anesthesia charges	4,668	14,004
Radiology	1,185	4,740
Total	$71,937	$216,996

have been successfully brought under control, the human death toll from *uncontrolled* diseases continues to rise. We could include alcoholism, automobile accidents, and the use of firearms in this category. If the deaths from these causes and the health care costs because of these factors were due to any infectious disease, the public and the politicians would make a huge outcry for the biomedical community to control this disease. However, when the factors for control are in their hands, they are reluctant to endorse any form of control.

Recent studies have pointed to the high-spiraling costs of health care and how they have increased over the years. In addition, there are always greater demands on the health facilities in an advanced society than in the backward countries. Thus, any effort to reduce the demand on the usage of the health care system by preventable means is worth considering. The yearly costs for treatment of gunshot wounds in this institution alone amount to almost a quarter of a million dollars. Our study did not include costs for emergency care, rehabilitation, physical therapy; these will result in even higher costs. Other major hospitals in Cleveland receive a large number of gunshot victims regularly, so it is easily seen that a total expense of $1½ million to $2 million could be incurred for treatment of gunshot wounds. The enormity of these costs is stressed when the local cost is projected on a state or national level. In a similar study at Charlotte, N.C., in 1969, the total cost for treating victims of gunshot wounds was similar to the figures in this study.[5] Their study also pointed out a feature noted in our material: the majority of victims were unable to pay the costs of medical treatment. This resulted in all taxpayers or working employees eventually bearing the burden of these costs by increased taxes or higher health insurance rates.

No accurate data are available on a national level on nonfatal injuries due to firearms, their effect, or their frequency in society. If the cost of hospitalization mentioned earlier is added to the costs of rehabilitation of the individual, the loss of wages from work, disability income, and other considerations, the figure would comprise a significant part of the gross national product. The financial burden of hospitalization and loss of work time could result in bankruptcy for a number of these victims.

A majority of states are enacting new legislation to combat this financial drain on individuals who cannot pay these costs and to compensate the health care institutions for their services. The state legislators have realized that, as elected government representatives, they have been unable to provide adequate protection from crime for the citizens. Therefore, several of them have initiated a program to provide state funds to reimburse victims of crime, or their survivors, for medical and hospital expenses and for loss of earnings.[9] Congress of the United States also is considering legislation to provide subsidies equal to 25 percent of their costs to those states who undertake to compensate innocent victims of violent crimes.[2] Such insurance and state assistance are available in other countries, such as the United Kingdom.

Violence is a perversion of human relations, but it probably is an inescapable part of human nature. It can be controlled, alleviated, or curbed to a certain extent, but it can never be abolished completely.[10] A very stimulating factor is the easy availability of handguns to persons lacking in responsible behavior. In large metropolitan areas, handgun injuries have a great impact on health care costs. We believe that gunshot wounds truly are a preventable disease which demands effective and immediate attention and concern from all responsible members of society.

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Obstetric Anesthetics in a Northcentral Ohio Community

A Brief Review

David J. Massa, M.D.

This is a brief review of 25 years' experience with obstetric anesthetics administered by anesthesiologists to patients living in a community in Northcentral Ohio.

The conclusion gained from this experience indicates that obstetric anesthetics for vaginal deliveries can be conducted competently by today's well-trained obstetricians.

THERE HAS BEEN A RENEWED interest in obstetric anesthesia by some of the anesthesiologists in Ohio. The specific question is to what extent should today's anesthesiologists be involved in providing their skills for the pregnant women in their immediate area. Since I and others have practiced in this particular field of medicine for nearly a quarter of a century, this report is presented for the benefit of our younger colleagues.

In 1951, anesthesia service was being provided to a community of approximately 90,000 people in Northcentral Ohio by a group of four anesthesiologists. This service included obstetric anesthesia. At that time, most of the obstetric practice was managed by general practitioners. They delivered about 80 percent of the newborn infants; two obstetricians delivered the other 20 percent. Most of the patients were given a general anesthetic of cyclopropane, nitrous oxide, and oxygen. (See the Table.)

During the Korean War, a new obstetrician came to the area to practice, and he encouraged the use of regional anesthesia (saddle block). While this concept of pain relief was recognized as effective, it was not readily accepted by the area anesthesiologists. Patients resisted spinal anesthesia because of fear, based on tales of woe heard from their neighbors. Anesthesiologists resisted spinal anesthesia primarily for technical reasons.

The advent of the new, tailor-made, disposable, spinal trays was timely. They were readily accepted by the anesthesiologist, and the incidents of patients with the haunting "spinal headaches" seemed to diminish. Also, the number of family physicians practicing obstetrics was decreasing.

Eventually, after one obstetric patient survived a severe aspiration problem, the group of anesthesiologists in this community became convinced that regional anesthesia was the method of choice, and general anesthesia was limited. Henceforth, we administered spinal anesthesia to our patients or we did not administer the anesthesia. The Table shows the types and number of anesthetics administered from 1951 through 1974 in our area.

Type and Number of Anesthetics Administered (1951-1974)

Year	General	Spinal	Total
1951	1,835	22	1,857
1952	1,784	15	1,799
1953	1,802	18	1,820
1954	1,904	55	1,959
1955	1,818	58	1,876
1956	1,834	177	2,011
1957	1,753	318	2,071
1958	1,290	740	2,030
1959	1,202	846	2,048
1960	1,057	971	2,028
1961	996	1,080	2,076
1962	944	937	1,881
1963	924	984	1,908
1964	865	1,021	1,886
1965	701	1,053	1,754
1966	361	1,371	1,732
1967	165	1,480	1,645
1968	0	1,630	1,630
1969	0	1,753	1,753
1970	0	1,842	1,842
1971	0	1,621	1,621
1972	0	1,507	1,507
1973	0	1,468	1,468
1974	0	1,495	1,495
Total	21,235	22,462	43,697

New obstetricians arriving in this community during these years were familiar with spinal anesthesia; they have been trained to administer saddle blocks. Therefore, they are attending over 90 percent of the deliveries, and administering regional anesthetics. The anesthesiologists felt they no longer were needed and that their services were not required.

During the years from 1951 through 1974, there was one death associated with delivery, and the average death rate for newborns was 1.3 percent.

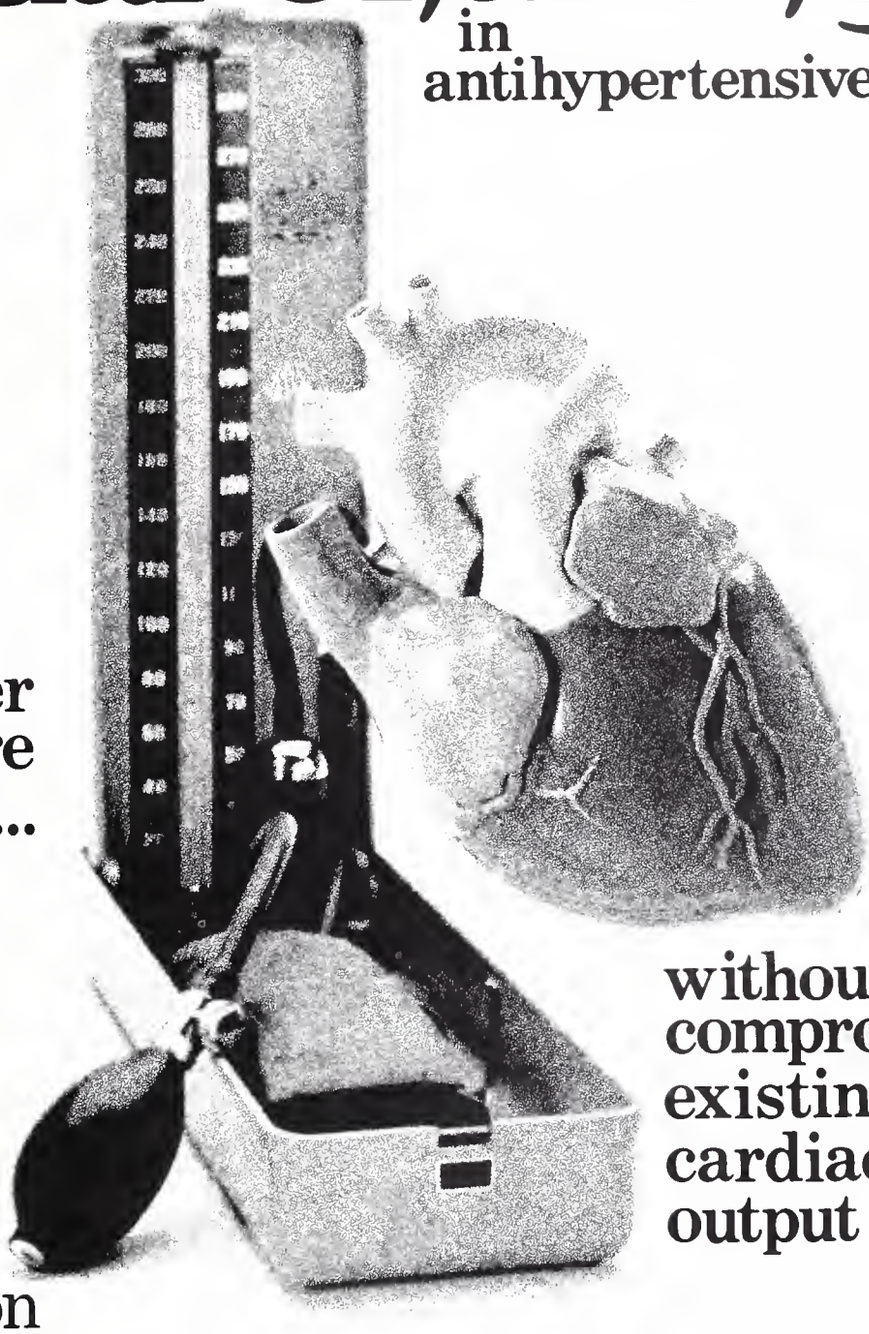
Since January 1975, obstetric anesthesia for vaginal deliveries in this community has been managed entirely by the obstetricians — and managed very well.

Dr. Massa, Anesthesiologist, Lexington, Ohio; Staff Member, Mansfield General, Peoples, and Richland Hospitals in Mansfield.

Submitted October 20, 1976.

A Dual Challenge

in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

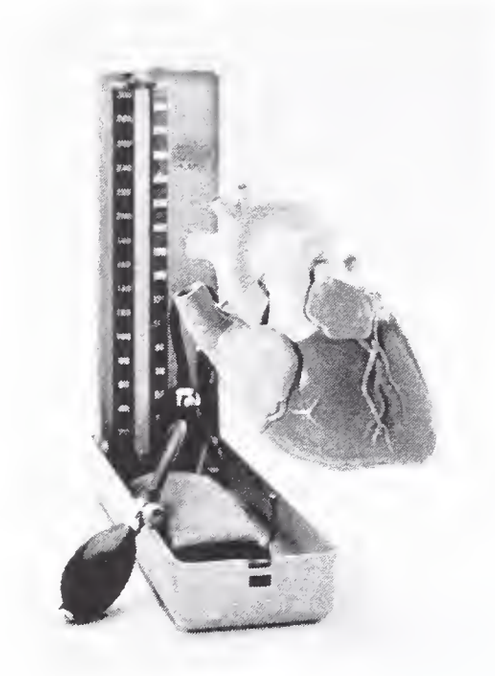
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07(707)

MSD MERCK SHARP & DOHME

THE OHIO STATE Medical Association News

New Disease Affecting Children

Physicians are alerted to watch for a new disease that primarily affects children age 3 months to 12 years, with a peak at age 3 years. Mucocutaneous lymph node syndrome (MLNS), also known as Kawasaki Disease, was first reported in Japan. Causing fever, reddening of the mouth, throat, lips, palms and soles, and swelling and disfiguration of the fingertips, the disease is usually a benign, self-limiting illness. However, the child can be quite ill for periods up to several months. A small percentage of the victims of the disease develop heart problems; and 2 percent of the small patients die, usually from heart complications.

The principal symptom of MLNS is a high fever lasting from one to two weeks, which does not respond to treatment with antibiotics. The red rash begins to appear on the third to fifth days of illness, followed by swelling of the hands and feet. Almost 7,000 cases of MLNS have been reported in Japan, and some 40 cases in the United States. The 40th case is described in the May 23, 1977 issue of the *Journal of the American Medical Association.*

Opinions and Reports Of the Judicial Council Published by the AMA

The AMA has released the first comprehensive revision of standards of professional responsibility for physicians. Entitled *Opinions and Reports of the Judicial Council,* the book is a compilation of interpretations, opinions, and statements of the AMA's Judicial Council with regard to application of the AMA's Principles of Medical Ethics to the everyday practice of medicine. Chapters of the book deal with the physician's responsibilities to the public, patient relations and medical responsibilities, office practices, interprofessional relations, and hospital relations. Reflecting the changing times in medicine, the book includes items on human experimentation in medical research, helping patients and families cope with terminal illness, the definition of death, and new medical technology. Copies are available from the Order Department, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

FTC Begins Investigation Of Possible HMO Boycotts

The Federal Trade Commission (FTC) has launched a nationwide investigation to determine whether physicians are boycotting health maintenance organizations (HMOs). According to Allen Palmer, FTC Assistant Director, the FTC will mail questionnaires to health maintenance organizations as part of a "general inquiry" into possible unlawful anticompetitive constraints facing HMOs. In September 1976, the FTC accepted an agreement from the Spokane, Washington Blue Shield Plan to halt an alleged boycott of physicians who participate in HMOs. Palmer said that the investigation was extended because the problem is of such a general nature that it could exist anywhere.

Cost of Health Care High On List of Consumer Concerns

The high cost of medical and hospital care is second on the list of consumer concerns, according to a recently released study on consumerism in America. Performed for the Sentry Insurance Company by the research firm of

(continued on page 446)



Singalongs, German Band, Cocktails and Keg Beer. All meats, desserts, and soups are made right here in Schmidt's immaculate kitchens. Ask to see. Buy Bratwurst and Bahama Mamas to take home. 4 blocks East of S. High St. on Kossuth, just a few blocks from your medical association headquarters.

Fantastic new private party and meeting rooms serving German Buffet or any size sizzling Top Grade steak dinners. Reservations taken for parties 35 and up. Call 444-5050.

Liveliest Spot In German Village

Noon and Night

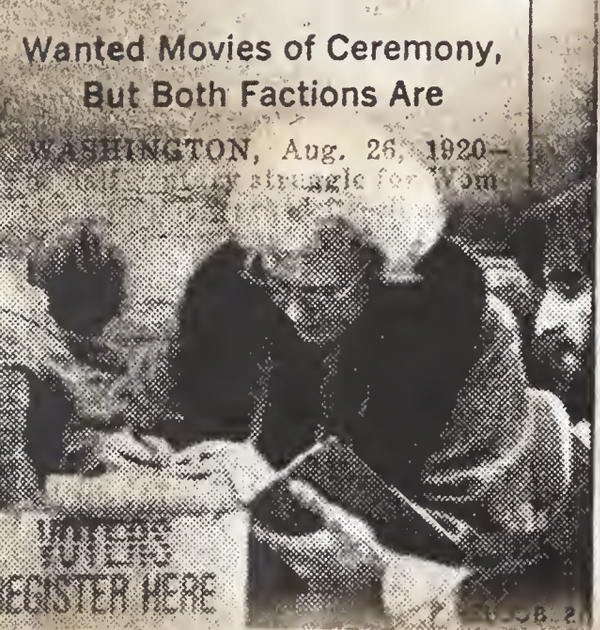
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws—He Co the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age per and counted upon to benefit 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the m "the cornerstone in a str which is being built but is means complete

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W. WASHINGTON, D. C. 20005

News *(continued from page 443)*

Louis Harris and Associates, the report entitled "Consumerism at the Crossroads" covers a wide range of topics. It shows that 77 percent of the American public is "worried a great deal" by high prices in general, and 69 percent singled out medical and hospital care in particular.

Of 25 industries and professions listed, hospitals were ranked as the second most likely target of future consumer activism; 44 percent of the 1,510 persons sampled said that the consumer movement should devote its attention to hospitals. The medical profession came right behind hospitals, with 42 percent of the public indicating that it should be the target of the consumer movement. Twenty percent of the public think hospitals are doing a good job; 25 percent think they are doing a poor job. In rating the medical profession, 18 percent said it was doing a good job and 25 percent said it was doing a poor job.

Patient Pamphlet on the Pill Released by College of OB/GYN

The American College of Obstetricians and Gynecologists has published an information booklet for patients which covers the risks and benefits of oral contraceptives. *Important Facts About the Pill* covers minor reactions to possible serious complications associated with the Pill. The most serious possible complication, the booklet states, is blood clotting that may lead in rare cases to heart attacks or strokes. The signs of trouble that oral contraceptive users should report to medical personnel are explained, along with the need for examinations when obtaining and continuing to take the pill.

Orders for the booklet should be sent to Publications Secretary, American College of Obstetricians and Gynecologists, Suit 2700, One East Wacker Driver, Chicago, Illinois 60601.

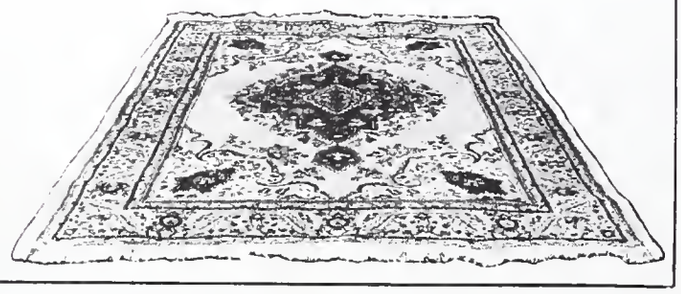
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ORIENTAL RUGS.

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Former Ohioan New Chairman of JCAH Accreditation Council For Psychiatric Facilities

A former director of the Ohio Department of Mental Health and Mental Retardation has been elected chairman of the Accreditation Council for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals. Kenneth D. Gaver, M.D., has served as a member of the Council since his appointment in 1973 by the National Association of State Mental Health Program Directors. Since 1974, Dr. Gaver has been the Commissioner of the Texas Department of Mental Health and Mental Retardation. He is a Fellow of the American Psychiatric Association.

The Accreditation Council for Psychiatric Facilities was established in 1970 to promote high quality in the provision of psychiatric and mental health care and services through voluntary programs of accreditation. The Council has established accreditation standards and survey procedures for five programs: psychiatric hospitals, children's and adolescents' facilities, alcoholism programs, drug abuse programs, and community mental health services.

Roche Vitamin Information Program

Hoffman-La Roche's Vitamin Information Program has reached more than 16 million people since it began in October 1976. The educational program has increased consumers' vitamin knowledge and has kept health professionals abreast of new vitamin developments through newspapers, television, and radio. Roche plans to expand the program to include public service announcements and presentations to groups with particular nutritional interests. John H. Kelly, Vice-President and General Manager of the Roche Chemical Division, said: "We hope to counteract people's vitamin misinformation with solid facts . . . it's important that we educate the public about good nutrition."

Califano Apologizes to AMA

Secretary of Health, Education, and Welfare Joseph A. Califano, Jr., has apologized to the AMA for the 65 percent error rate in HEW's list of physicians who earned $100,000 or more in Medicare reimbursements in 1975. He wrote AMA Executive Vice-President James H. Sammons, M.D.: "I am deeply distressed at the number

(continued on page 509)

When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

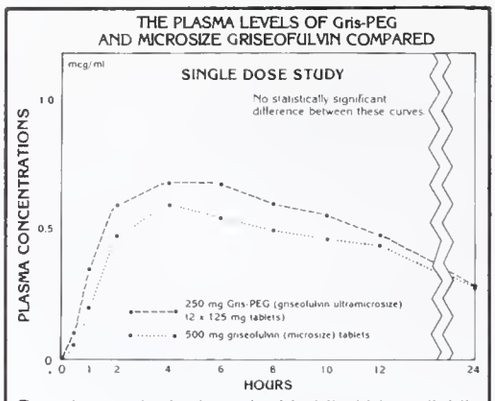
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



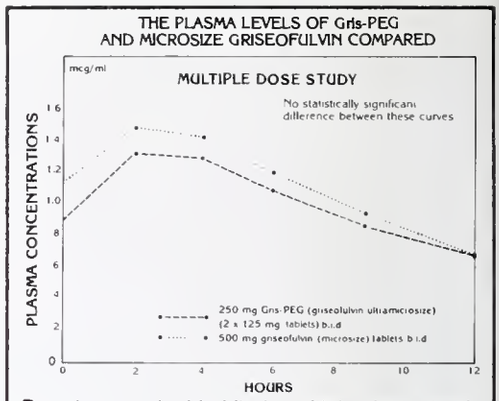
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION
Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION
Microbiology Griseotulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton* It has no effect on bacteria or other genera of fungi.

Human Pharmacology The peak plasma level found in fasting adults given 0 25 g of Gris-PEG occurs at about four hours and ranges between 0 37 to 1 6 mcg/ml

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1 2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy

Griseotulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions

INDICATIONS
Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS
This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS
Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology Chronic feeding of griseofulvin, at levels ranging from 0.5 to2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS
Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS
When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION
Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks, *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults. A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily, children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED
Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets

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CME



AMA-Ohio State Medical Association Brings CME to Ohio

At Sawmill Creek Lodge—Oct. 7-9, 1977

Ohio State Medical Association invited the AMA to cooperate in a continuing medical education program for its members. Non-AMA members are welcome and there will be AMA Auxiliary seminars designed specifically for the physician's spouse. Amid 300 acres of natural woods and ponds, Sawmill Creek offers an ideal environment for learning.

Classes will be over at midday, so reserve your afternoons and evenings for Sawmill's abundant activities. For indoor swimming, Sawmill has a beautiful pool. There are also adjacent saunas and a hydrotherapy pool.

If the autumn weather is as beautiful as it should be, head for Lake Erie for boating, fishing, or strolling along the 3,000 feet of white sand beach. Tennis or golf anyone? Sawmill Creek has an 18-hole championship course and three all-weather tennis courts (contact hotel for advance reservations). Paddle tennis, table tennis, and billiard rooms round out the sports activities.

Gracious rusticity and comfortable elegance are the hallmarks of Sawmill Creek. These qualities are reflected in the restaurants that range from the Bird Cage with its verdant foliage to the Crow's Nest which features delectable gourmet fare and nightly entertainment. Camaraderie and superb cuisine—the perfect way to end your study day.

On Friday afternoon a bus will be provided for a tour of the renowned Tiffin Glass Works and on Saturday afternoon you may visit Milan, Ohio, to tour antique shops and the home of Thomas Edison. A poolside barbecue will be featured Saturday evening.

SEE OVERLEAF FOR CME COURSE REGISTRATION FORM & FOR HOTEL REGISTRATION FORM or phone inquiries to: **AMA Department of Meeting Services at (312) 751-6155.**

AMA

CME at Sawmill Creek—Oct. 7-9, 1977

Courses Offered at Huron, Ohio

Friday, 7:30 AM-12:30 PM (each 5 hours: $55)

N-1. Blood Gases & Electrolytes
N-2. Basic Life Support (Cardiopulmonary Resuscitation—CPR)
N-3. Dermatology for Nondermatologists
N-4. Cardiac Arrhythmias, Recognition, Significance, & Treatment
N-5. Concepts of Immunology as Applied in Everyday Practice

Saturday, 7:30 AM-12:30 PM (each 5 hours: $55)

N-6. Preventive & Predictive Medicine for Coronary Artery Disease
N-7. Fetal & Perinatal Monitoring
N-8. Chest X-ray—What Do You See?
N-9. Office Management

Sunday, 7:30 AM-12:30 PM (each 5 hours: $55)

N-10. Preventive & Predictive Medicine in GI Diseases
N-11. Recognition & Treatment of Common Eye Problems
N-12. Headache
N-13. Pulmonary Disease

Saturday & Sunday, 7:30 AM-5:30 PM & 7:30 AM-12:30 PM (14-hour, 2-day course: $150)

N-14. Advanced Life Support (Cardiopulmonary Resuscitation—CPR)

CME Course Registration Form
AMA's Huron CME Regional Meeting

Please circle the course, by codes, that you wish to attend:*

Friday	Saturday	Sunday	Saturday & Sunday
N-1	N-6	N-10	N-14
N-2	N-7	N-11	
N-3	N-8	N-12	
N-4	N-9	N-13	
N-5			

AMA Auxiliary
_____Check here for info on AMA Seminars

Payment must accompany choice of courses and social events requested on this registration coupon:

_____Friday afternoon , Oct. 7, 1977 • Tiffin Glass Works Tour— $12.

_____Saturday afternoon, Oct. 8, 1977 • Antique Shop Tour—$12.

_____Saturday evening, Oct. 8, 1977 • Poolside Barbecue & Cocktails—$15.

_____Please add $15 if you are a nonmember of AMA.

_____

*Courses N-1 through N-13 are 5 hours each, presented once: $55 each. Course N-14 is a 14-hour, 2-day course, presented once: $150. All medical students and residents are entitled to a 50% discount on course registration fees. ($10 per credit hour of Category 1 is standard rate.) Breakfast **only** will be provided for all course registrants.

Name _____
(please print or type)
Office Address _____
City/State/Zip Code _____
Office Phone No. (____) _____ _____

Mail this tear-out form with your check to:

American Medical Association
Department of Meeting Services
535 North Dearborn Street
Chicago, Illinois 60610

Hotel Reservations/Sawmill Creek Lodge
AMA-Ohio State Medical Association
Regional Meeting—Oct. 7-9, 1977

Return to: **Sawmill Creek Lodge,**
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P. O. Box 358, Huron, Ohio 44839

NOTE: September 6, 1977, is the last date that bedrooms are being held for this meeting. After this cut-off date, reservations will be accepted only if rooms are available.

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List ages of children under 12 years old _____

Total number of persons _____

ARRIVAL DATE _____ TIME _____ AM PM

DEPARTURE DATE _____ TIME _____ AM PM

Check for $_____ is enclosed for the Sawmill Creek Resort, dated _____

Name _____
(please print or type)
Office Address _____
City/State/Zip Code _____
Office Phone No. (____) _____ _____

The Ohio State Medical Association Pharmacology Today

Management of the Drug Overdose Patient

Part II. Specific Antidotes

Joseph R. Bianchine, M.D., Ph.D.
Daniel Couri, Ph.D.

SPECIFIC ANTIDOTES that are clinically effective are available for only a few drugs. Important examples of these are summarized in the accompanying Table. Certain of these antidotes warrant particular discussion.

Deferoxamine (Desferal®) is a very specific chelater for the ferric ion, forming a water-soluble compound (ferrioxamine) that is promptly excreted in the urine. Hence, deferoxamine is very effective in ridding the body of excess iron present in acute iron intoxication. Without this specific treatment, there is a 50-percent mortality rate in pediatric cases.

The principal manifestations of acute iron intoxication include vomiting, bloody diarrhea, and circulatory collapse. Complicating coma and hepatic toxicity also may occur.

Deferoxamine causes several side effects including hypotension (histamine release), rash, and gastrointestinal irritation.

Pralidoxime (Protopam®—sometimes referred to as 2-PAM), a "cholinesterase reactivator," is very useful in the treatment of anticholinesterase intoxication especially when coupled with large doses of atropine. In man, agricultural insecticides with anticholinesterase activity cause profound "muscarinic" and "nicotinic" symptoms. These include vomiting, abdominal cramps, diarrhea, salivation, bradycardia, and hypotension. Skeletal muscle becomes weak and paralyzed. Death is caused by paralysis of respiratory muscles and shock. Pralidoxime splits off the toxic cholinesterase inhibitor from the cholinesterase enzyme, thus, "reactivating" cholinesterase. Within minutes of administration, it results in striking antidotal effects.

Side effects of pralidoxime are surprisingly mild if it is given in the dosage suggested.

(continued on page 452)

Selected Toxicants, Specific Antidotes, and Clinical Management

Toxicant	Antidote	
Iron (ferrous sulfate)	Deferoxamine (Desferal)	8 gm orally by nasogastric tube followed by 0.5 gm intramuscularly every 4 hrs for two doses. Additional doses may be required by clinical condition, but no more than 6 gm should be given parenterally in 24 hrs. May be given intravenously if patient is in shock.
Cholinesterase inhibitors (malathion, parathion)	Pralidoxime (Protopam—2-PAM)	1 gm in 250 ml glucose, intravenously in 5 to 10 minutes. May be repeated.
	Atropine	2 mg intravenously, repeated as needed to control muscarinic symptoms
Methanol	Ethanol	Sodium bicarbonate intravenously, slowly Ethanol: 5 percent solution, 1.0 to 1.5 ml/kg intravenously
Coumarin anticoagulants (warfarin, dicumarol)	Vitamin K_1 (AquaMephyton)	25 mg intravenously, given slowly
Morphine, heroin-related derivatives	Naloxone (Narcan)	0.1 mg/kg intravenously. Repeat dose if necessary
D-propoxyphene (Darvon)	Naloxone (Narcan)	0.1 mg/kg intravenously. Repeat dose if necessary

Specific Antidotes *(continued)*

Naloxone (Narcan®) is a pure, narcotic, antagonist drug almost devoid of agonist effect. Consequently, intravenous administration of naloxone promptly reverses the central nervous system and gut effects of opiates. For example, the marked respiratory depression and coma of opiate overdose is antagonized within a minute or two of administration. Importantly, naloxone has practically no depressant action of its own on the central nervous system. Thus, this antagonist can be administered safely to a patient in whom the etiology of respiratory depression is uncertain. Consequently, if respiratory depression is not caused by a narcotic drug, naloxone will not depress it further.

Two important clinical observations are cited. Opioid-dependent patients treated with naloxone may note narcotic withdrawal symptoms within minutes of administration. Intoxication with analgesic d-propoxyphene hydrochloride (Darvon®), chemically related to methadone, also is reversed with naloxone.

Unfortunately, no *specific* antidotal therapy is available for most drug intoxications. In these cases, supportive therapy must be directed toward control of toxic manifestations as they appear. Hypotension and hypoxia must be controlled as soon as they appear. It is clear that aggressive, symptomatic management, coupled with specific antidotal treatment when available, usually results in complete recovery of the drug-intoxicated patient.

It is surprising to us that our society knows so little about the danger of methanol intoxication. Methanol is oxidized by hepatic alcohol dehydrogenase to formaldehyde and formic acid, both very toxic metabolites indeed. Ethanol has a higher affinity than methanol for alcohol dehydrogenase. Consequently, ethanol is a very effective inhibitor of methanol oxidation in vivo. Ethanol is metabolized at a rate five times greater than that of methanol. Therefore, repeat doses of ethanol are required to serve as an antidote for methanol intoxication. Acidosis, also a prominent feature of methanol intoxication, can be reversed by an infusion of sodium bicarbonate.

Dr. Bianchine, Columbus, Chairman and Professor, Department of Pharmacology, and Professor, Department of Medicine, The Ohio State University College of Medicine.

Dr. Couri, Columbus, Professor of Pharmacology, and Director, Toxicology Division, The Ohio State University College of Medicine.

Submitted March 23, 1977. Part I appeared in Vol. 73, No. 6 (June 1977) of *The Journal.*

Generic and Trade Names of Drugs

Deferoxamine mesylate—Desferal (CIBA Pharmaceutical Co.)
Pralidoxime chloride—Protopam (Ayerst Laboratories)
Naloxone hydrochloride—Narcan (Endo Laboratories)

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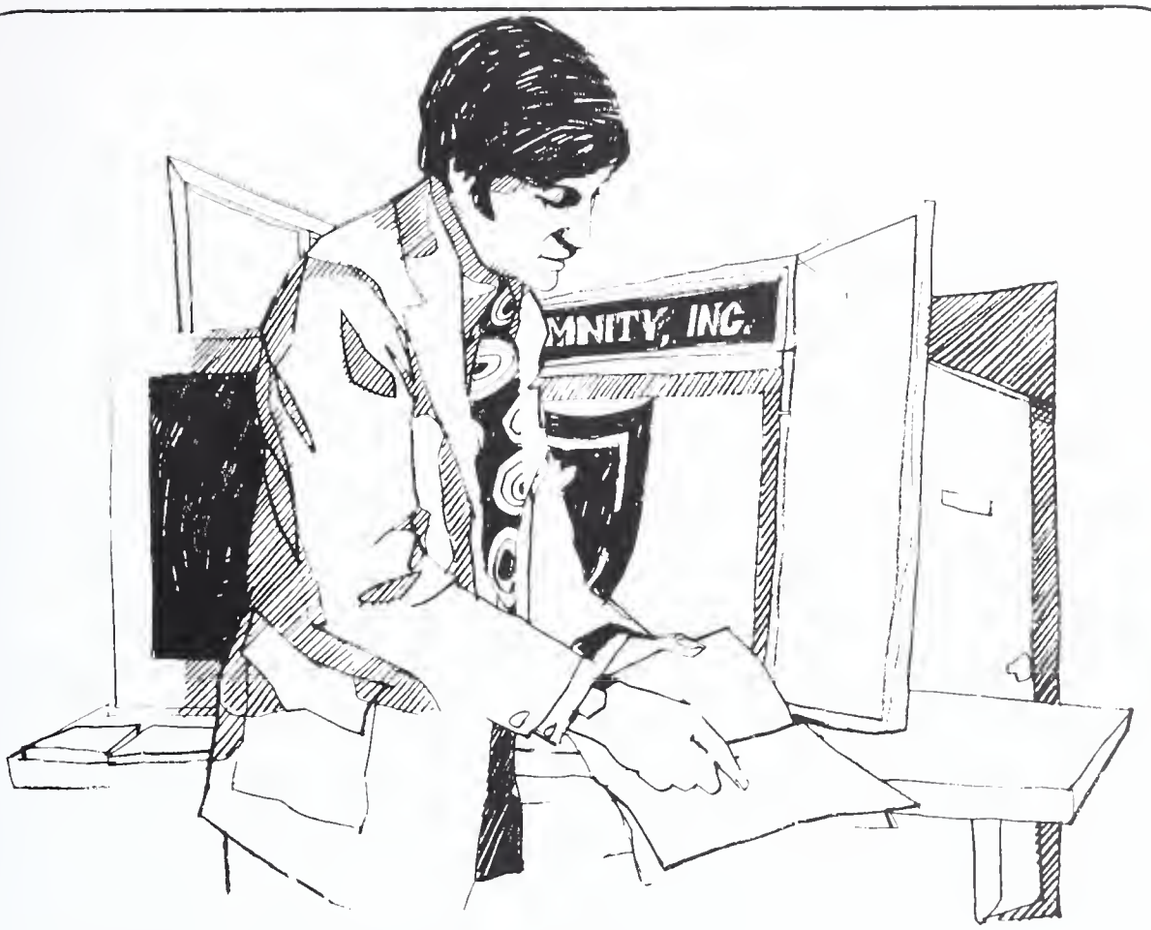
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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

Periodic Programs

CITY-WIDE OB/GYN CLINICAL GRAND ROUNDS: Second Wednesday, each month, 8:00 AM; Miami Valley Hospital, Dayton; cosponsors: Wright State University School of Medicine Department of Obstetrics and Gynecology and Kettering Medical Center; 1 credit hour; contact: Alfred Hicks, II, M.D., 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CITY-WIDE OB/GYN CLINICAL GRAND ROUNDS: Fourth Wednesday, each month, 8:00 AM; Miami Valley Hospital, Dayton; cosponsors: Wright State University School of Medicine Department of Obstetrics and Gynecology and Good Samaritan Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

MEDICAL AND SURGICAL GRAND ROUNDS: Every Thursday, 12 NOON-2 PM, lunch served; Community MedCenter Hospital, Marion; 1 credit hour; contact: Jose G. Albernaz, M.D., The Frederick C. Smith Clinic, 1040 Delaware Avenue, Marion 43302, phone: 614/382-8251.

Single Course Offerings

July 1977

OHIO VALLEY SOCIETY FOR PLASTIC AND RECONSTRUCTIVE SURGERY: July 19-22; The Inn at the Peak, Clymer, New York, sponsor: AMA; 12 credit hours; fee: $50; contact: Frank M. Tooze, M.D., 104 East 2nd Street, Erie, Pennsylvania 16507, phone: 814/455-4496.

ALCOHOLISM IN INDUSTRY: July 21; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue Marion 43302, phone: 614/383-6301.

CARE OF THE HIGH-RISK MOTHER AND INFANT: July 21, 22; Fawcett Center for Tomorrow, Columbus; sponsor: OSU College of Medicine: Departments of Obstetrics and Gynecology and Pediatrics, Ohio Department of Health, and Bureau of Maternal Child Health; cosponsor: OSU Center for Continuing Medical Education; 12 credit hours; fee: $25, Students/Physicians-in-Training—no charge; contact: Rick Panzironi, University Hospital, N-118, 410 W. 10th Avenue, Columbus 43210, phone: 614/422-7525 or 422-7526.

CHRONIC MEDICATIONS AND ANESTHESIA: July 23, 8:30 AM; Mercy Medical Center, Springfield; sponsor: Mercy Medical Center; 1 credit hour; contact: Ernest Henson, M.D., 1343 Fountain Boulevard, Springfield 45501, phone: 513/399-7121, ext. 341.

August 1977

OHIO ACADEMY OF FAMILY PHYSICIANS 27TH ANNUAL SCIENTIFIC ASSEMBLY: August 5-7; Sheraton-Columbus Motor Hotel, Columbus; 14 credit hours; various fees for activities; contact: Mrs. Florence Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

IMMUNOLOGY: (William F. Hughes, M.D., speaker); August 11; Community Medcenter Hospital, Marion; sponsor: Community Medcenter Hospital; 1 credit hour; contact: Robert R. Tracht, Administrator, Communiy Medcenter Hospital, 1050 Delaware Ave., Marion 43302, phone: 614/383-6301.

September 1977

THE CORE CONTENT REVIEW OF FAMILY MEDICINE: September 1977 through February 1978; Self-Assessment Exam; sponsor: Ohio Academy of Family Physicians; cosponsor: Connecticut Academy of Family Physicians; 24 credit hours; fee: AAFP mbr. $40; Non-mbr. $60; Residents $20; contact: Douglas P. Longenecker, M.D., St. Elizabeth Medical Center, 601 Miami Boulevard, West, Dayton 45408, phone: 513/223-5859.

NUCLEAR MEDICINE IN CARDIOLOGY: September 1; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tract, Administrator, Community MedCenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301, ext. 292.

AMERICAN THYROID ASSOCIATION ANNUAL MEETING (Clinical Day Program): September 7, 8:55 AM; Cleveland Plaza Hotel, Cleveland; sponsor: American Thyroid Association; 6 credit hours; contact: Alvin B. Hayles, M.D., Mayo Clinic, Rochester, Minnesota 55901.

NUCLEAR MEDICINE - ULTRASOUND - COMPUTERIZED TOMOGRAPHY, A CONFRONTATION: September 8-10; Marriott Inn, Cleveland; 20 credit hours; fee $400, $250 residents; contact: D. Bruce Sodee, M.D., Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

FIRST DECADE OF BYPASS GRAFT SURGERY FOR CORONARY ARTERY DISEASE: September 15-17; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 15 credit hours; fee: $250; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

THE OHIO STATE Medical Association Obituaries

JOSEPH GEORGE CROTTY, M.D., Cincinnati; University of Cincinnati College of Medicine, 1933; age 70; died April 20; member OSMA and AMA.

WILLIAM P. EDMUNDS, M.D., Clearwater, Florida; University of Michigan Medical School, Ann Arbor, Michigan, 1912; age 91; died May 4; member OSMA and AMA.

GORDON L. ERBAUGH, M.D., Venice, Florida; University of Cincinnati College of Medicine, 1923; age 83; died May 9; member OSMA and AMA.

MELVIN GILLETTE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1951; age 51; died May 4; member OSMA and AMA.

CHARLES S. HOUGH, M.D., Chicago, Illinois; Meharry Medical College School of Medicine, Nashville, Tennessee, 1926; age 86; died May 4.

J. BYRON LEE, M.D., Dayton; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1951; age 56; died May 4; member AMA.

FRED J. MACKLEY, M.D., Hamilton; Creighton University School of Medicine, Omaha, Nebraska, 1941; age 69; died April 12; member OSMA and AMA.

JOHNSON McGUIRE, M.D., Cincinnati; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1924; age 77; died May 16; member OSMA and AMA.

JOSEPH D. McNERNEY, M.D., Prince George, Virginia; Ohio State University College of Medicine, 1917; age 84; died May 5; member OSMA and AMA.

EDWARD MICHALENKO, M.D., Randolph, New Jersey; Northwestern University Medical School, Chicago, Illinois, 1933; age 77; died April 23; member OSMA and AMA.

MACK ELGIN MOORE, M.D., Piketon; Temple University School of Medicine, Philadelphia, Pennsylvania, 1933; age 68; died April 23; member OSMA and AMA.

GERALD C. RANKIN, M.D., North Olmsted; McGill University Faculty of Medicine, Toronto, Ontario, Canada, 1924; age 76; died May 12.

SIGMOND J. SHAPIRO, M.D., Warren; Jefferson Medical College, Philadelphia, Pennsylvania, 1925; age 76; died May 16; member OSMA and AMA.

IOLA A. SIVON, M.D., Gahanna; Case Western Reserve School of Medicine, 1939; age 63; died May 23; member OSMA and AMA.

KENNETH LYLE UPP, M.D., Athens; University of Kansas School of Medicine, Kansas City, Kansas, 1953; age 51; died May 23; member OSMA and AMA.

FRANK VECCHIO, M.D., Cleveland; Case Western Reserve School of Medicine, 1928; age 72; died May 11; member OSMA and AMA.

★

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THE OHIO STATE Medical Association

Medical School Highlights

Medical Schools Receive AMA-ERF Funds at OSMA Annual Meeting

During the 1977 OSMA Annual Meeting, the deans of Ohio's medical schools accepted checks on behalf of their respective schools from the American Medical Association's Education and Research Foundation (AMA-ERF). Shown receiving the checks from Philip B. Hardymon, M.D., Chairman of Ohio's Committee for AMA-ERF, are:

COLUMN ONE (top to bottom): (1) Theodore J. Castele, M.D., representing Case Western Reserve School of Medicine. (2) John P. Kemph, M.D., Vice-President for Academic Affairs and Dean of the Medical Faculty, Medical College of Ohio at Toledo. (3) Stanley W. Olson, M.D., Provost, Northeastern Ohio Universities College of Medicine.

COLUMN TWO (top to bottom): (1) Henry G. Cramblett, M.D., Dean, The Ohio State University College of Medicine. (2) Robert S. Daniels, M.D., Dean, University of Cincinnati College of Medicine. (3) John R. Beljan, Dean, Wright State University School of Medicine.

(See page 468 of this issue for complete story.)













(Medical School Highlights continued on page 465)

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Medical School Highlights

Liaison Committee on Medical Education Scrutinized by FTC

The status of the Liaison Committee on Medical Education (LCME) as the only body recognized by the U.S. Office of Education to accredit U.S. medical schools is being questioned by the Federal Trade Commission's (FTC) Bureau of Competition on the basis of a potential conflict-of-interest problem. A May 23 FTC statement reporting steps taken by the Bureau in communications with the Office of Education expresses "previously stated concern with the fact that LCME is tied to and heavily influenced by the American Medical Association." The AMA appoints 6 of the LCME's 15 members, contributes half of its operating funds, and is directly involved in the administration of the LCME.

An Office of Education advisory committee recently recommended that the LCME be recognized for an additional two years rather than the customary four years. The FTC proposes that this recognition be granted for only one year with the specific requirement that the LCME make "significant and unmistakable changes."

Northeastern Ohio Universities College of Medicine

Project MARS (seminars for minority and rural students) is being offered for a second year by Northeastern Ohio Universities College of Medicine. Under the direction of Dean Robert A. Liebelt, M.D., Ph.D., the Project provides students with information concerning health-related careers and offers motivation to enter these fields. Thirty-seven students who are in their second or third year in high school or academy in northeastern Ohio have enrolled for the Saturday programs. Although the Project also serves to enlarge the number of students eligible for recruitment into Phase I of the combined BS/MD degree program of the College of Medicine, it does not guarantee admission to the program. Faculty for the Project is selected from The University of Akron, Kent State University, the College of Medicine, and the associated community hospitals.

Wright State University School of Medicine

An interdisciplinary program currently being planned at Wright State University School of Medicine will prepare physicians to deal with the multifaceted problem of the alcoholic or problem drinker. Harvey Siegal, Ph.D., Assistant Professor in the Department of Medicine in Society, in conjunction with Miles Connor, Executive Director of the Western Ohio Regional Alcoholism Center, has received a $36,000 grant from the Ohio Department of Health to design the curriculum which will offer courses throughout the school's four-year curriculum. The proposal also calls for the use of community human resources in training situations.

According to Dr. Siegal, ideally, this curriculum will enable a primary care physician to understand the alcohol abuse case, to be supportive, and to develop a therapeutic relationship which would likely include referral to a community treatment agency.

Dr. Siegal stated: "In general, whether we speak of the physician, nurse, counselor, or social worker, we are seeking a level of understanding. Our goal is to educate health care professionals who understand the social milieu which produces 'social casualties.'

"A student in our program will understand the genesis of the alcohol problem, its effects on employment, and its impact on social and family life. He or she will then know how to move the social casualty into a milieu which provides the appropriate kind of treatment."

Case Western Reserve School of Medicine

MICHAEL J. DUNN, M.D., has been named the fifth occupant of the Hanna-Payne Chair of Case Western Reserve School of Medicine. Associate Professor of Medicine and Associate Director of the Department of Medicine at the Vermont College of Medicine, Dr. Dunn will be Hanna-Payne Professor of Experimental Medicine in the CWRU Department of Medicine. In addition, he will be the Director of the Renal Division of the Department of Medicine at University Hospitals and Cleveland Veterans Administration Hospital.

University of Cincinnati College of Medicine

RAYMOND R. SUSKIND, M.D., Director of the Department of Environmental Health and of the Kettering Laboratory at the University of Cincinnati College of Medicine, has been awarded the 1977 Citation for Health Achievement in Industry presented by the American Occupational Medical Association. The association is an international organization of physicians who provide health care for the employees of private enterprises, governmental services, and other institutions. The citation presented Dr. Suskind read in part: "for his work at the Kettering Laboratory in developing and expanding outstanding programs for professionals in all fields of occupational health at a time of great need."

The Ohio State University College of Medicine

The Ohio State University will host the 1977 fall meeting of the American Society for Pharmacology and Experimental Therapeutics on August 21-25. Sponsored by the Departments of Pharmacology in the Colleges of Medicine, Pharmacy, Veterinary Medicine, and Dentistry, the meeting will draw international guests. Phillip B. Hollander, Ph.D., Professor of Pharmacology in the College of Medicine, is program chairman.

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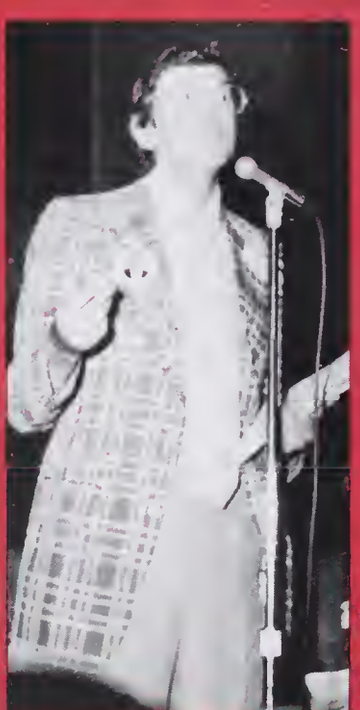


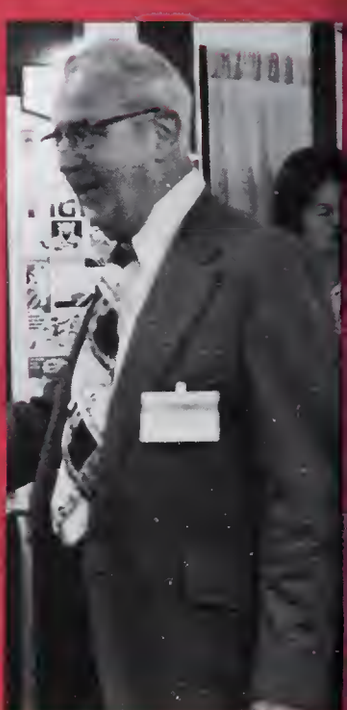












ABOVE (top to bottom): (1) Left to right: Benjamin H. Reed, Jr., M.D.; Harry L. Snyder, M.D.; and Peter A. Overstreet, M.D. (2) Left to right: Joseph Yut, M.D.; John H. Budd, M.D.; and Brian S. Harrold, M.D. (3) Left to right: County society executives Lelan Woodmansee, Howard Rempes, Ray Sullivan, James Imboden, and Jean Armour. (4) Left to right: Howard S. Siegel, M.D., and Valentin F. Mersol, M.D.

Proceedings of the OSMA House of Delegates 1977 Annual Meeting

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 6:30 PM, Sunday, May 15, 1977, at the Sheraton-Columbus Hotel, Columbus, with President George N. Bates presiding.

The Invocation was offered by Dr. George W. Paulson, Columbus, a member of the OSMA Committee on Medicine and Religion.

Dr. Bates introduced James L. Golden, Ph.D., Director of Communications, The Ohio State University, the parliamentarian obtained in accordance with Resolution No. 1-76.

Dr. James W. Kilman, Columbus, President of the Academy of Medicine of Columbus and Franklin County, welcomed the delegates and guests to Columbus.

Dr. Roger Blackwell was introduced and gave a preview of his program, "Public Attitudes Toward Health Care and Malpractice Solutions," scheduled for Monday, May 16, at 1:30 PM in the Assembly Hall, Veterans Memorial Building.

REPORT ON DELEGATES PRESENT

Dr. Homer A. Anderson, Columbus, Chairman of the Credentials Committee, reported that out of 181 delegates eligible to vote, 161 were seated. A number of alternate delegates, guests, officers of county medical societies, and executive secretaries were in attendance.

1976 MINUTES APPROVED

The minutes of the 1976 sessions of the House of Delegates, as published in the July and September 1976 issues of *The Ohio State Medical Journal,* were approved by official action.

PRESIDENT'S ADDRESS

Mr. Page then introduced President George N. Bates, Toledo, who delivered his Presidential Address. (See text of address in this issue.)

After the Address, Dr. Bates received the applause of the House.

INTRODUCTION OF OUT-OF-STATE GUEST

Dr. Bates introduced the following out-of-state guest: Dr. Joseph A. Smith, Dunbar, West Virginia, President-Elect of the West Virginia State Medical Association.

INTRODUCTION OF GUESTS

Dr. Bates introduced the following guests: Karleen Streitenberger, R.N., Columbus, 1st Vice President, Ohio Nurses Association; Philip Golding, D.O., North Olmsted, President-Elect, Ohio Osteopathic Association; Jamille Jamra, Esq., Toledo, President, Ohio State Bar Association; Mr. Henry E. Agin, Columbus, representing the Ohio State Pharmaceutical Association; H. Judson Reamy, M.D., Dover, President, Ohio Academy of Family Physicians; Mrs. William Myers, Circleville, President, and Mrs. Albert May, Marion, President-Elect, of the Ohio State Medical Association Auxiliary; Ms. Louise Fuller, Euclid, President, Ohio State Society of Medical Assistants.

REPORT OF OSMA AUXILIARY PRESIDENT

Mrs. William Myers, Circleville, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. J. Hutchison Williams. She addressed the House of Delegates on various activities of the Auxiliary during her term of office.

INTRODUCTION OF OSMA PAST PRESIDENTS

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. H. M. Clodfelter, Columbus; Dr. Charles L. Hudson, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. George W. Petznick, Cleveland; Dr. Henry A. Crawford, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. P. John Robechek, Cleveland; Dr. William R. Schultz, Wooster, Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; and Dr. Maurice F. Lieber, Naples, Florida.

(continucd on page 468)



LEFT TO RIGHT: Oscar W. Clarke, M.D.; OSMA Executive Director Hart F. Page; and Thomas W. Morgan, M.D.

LEFT (top to bottom): (1) Left to right: R. Alan Baker, M.D.; John H. Taylor, M.D.; Henry Diederichs, M.D.; Isador Miller, M.D.; Ernest Winterhoff, M.D.; and Paul C. Vernier, M.D. (2) OSMA Staff members David C. Torrence and Gail E. Dodson, who directed the Annual Meeting. (3) Left: Stanley J. Lucas, M.D.; Right: Anthony J. Ruppersburg, M.D.

House of Delegates' Proceedings

INTRODUCTION OF AMA PRESIDENT-ELECT

Dr. Bates then introduced Dr. John H. Budd, Cleveland, President-Elect of the American Medical Association. Dr. Budd received a standing ovation from the House of Delegates and responded with a brief address.



LEFT TO RIGHT: John H. Budd, M.D.; Oscar W. Clarke, M.D.; and OSMA Staff members Jerry J. Campbell and Charles W. Edgar.

INTRODUCTION OF THE 1977 SHEEN AWARD WINNER

Dr. Robert M. Zollinger, Columbus, winner of the 1977 Sheen Award of the AMA, was introduced and was escorted to the podium by Dr. Richard L. Meiling. Dr. Zollinger received a standing ovation from the House of Delegates. He responded with remarks appropriate to the occasion.



LEFT TO RIGHT: Robert M. Zollinger, M.D.; Richard L. Meiling, M.D.; and Henry A. Crawford, M.D.

INTRODUCTION OF AMA BOARD OF TRUSTEES MEMBER

Dr. Bates then introduced Dr. James M. Blake, Schenectady, New York, a member of the AMA Board of Trustees.

INTRODUCTION OF THE CHAIRMAN OF THE OHIO DELEGATION TO THE AMA

Dr. Bates next introduced Dr. P. John Robechek, Cleveland, Chairman of the Ohio Delegation to the AMA, who made a brief announcement with regard to the campaign of Dr. W. J. Lewis, Dayton, for Vice Speaker of the AMA House of Delegates.

GOVERNOR'S ADVISORY COMMISSION ON MALPRACTICE

Dr. James L. Henry, Chairman of the Governor's Advisory Commission on Malpractice, reviewed the April 20, 1977 report of the Commission to the Governor.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Bates then introduced former members of the Council: Dr. Chester H. Allen, Portsmouth; Dr. Philip B. Hardymon, Columbus; Dr. Paul F. Orr, Perrysburg; Dr. Carter L. Pitcher, Portsmouth; and Dr. George J. Schroer, Ft. Loramie.

OTHER GUESTS INTRODUCED

Dr. Bates introduced the following: Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; Mr. Oren "Bud" Wright, Chicago, Illinois, Assistant to the Executive Vice-President of the AMA and James E. Pohlman, Esq., Columbus, OSMA Legal Counsel.

REPORT OF THE PRESIDENT OF PICO

Mr. Joseph K. Gilmore, President of Physicians Insurance Company (PICO) of Ohio, was introduced and reviewed the history and current status of the company. He reported to the House of Delegates that PICO started sales on December 27, 1976, and that PICO had sold $5 million of stock as of May 13, 1977. Mr. Gilmore stated that currently PICO had 1,400 policyholders and was growing at a rate slightly ahead of the August 1976 projection. PICO staff had been recruited from insurance-related organizations, and the management background of the staff was excellent.



PICO President Joseph K. Gilmore addresses the House.

AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committtee for the American Medical Association's Education and Research Foundation (AMA-ERF), made the presentation of the AMA-ERF checks as follows:

Dr. Theodore J. Castele, representing Case Western Reserve School of Medicine, Cleveland: $11,992;

Dr. Henry G. Cramblett, Dean, The Ohio State University College of Medicine, Columbus: $17,221.18;

Dr. John P. Kemph, Vice-President for Academic Affairs and Dean of the Medical Faculty, Medical College of Ohio at Toledo: $5,496.07;

Dr. Robert S. Daniels, Dean, University of Cincinnati College of Medicine, Cincinnati: $18,638.87;

Dr. Stanley W. Olson, Provost, Northeastern Ohio Universities College of Medicine, Kent: $7,868.04; and

Dr. John R. Beljan, Dean, Wright State University School of Medicine, Dayton: $5,493.21.

Dr. Bates expressed thanks on behalf of the Association to Dr. Hardymon for his efforts with regard to this fine project. (See "Medical School Highlights," this issue, for photographs.)

PLAQUES AND CERTIFICATES OF APPRECIATION

Dr. Maurice F. Lieber, Naples, Florida, received a plaque in appreciation of his service to the Association as a retiring member of the Council.

A certificate of appreciation was presented to Dr. Howard S. Madigan, Toledo, for his service as chairman of the Standing Committee on Education and the Commission on Medical Education.

The following retiring chairmen of special committees were honored: Dr. Maurice F. Lieber, Naples, Florida, Ohio Medical Indemnity Committee; and Dr. Robert S. Heidt, Cincinnati, Committee on Emergency and Disaster Medical Care. Dr. Heidt addressed the House with regard to the work of the Committee.

Dr. Richard L. Meiling, Columbus, was presented a certificate of appreciation for his service to the Association as a retiring member of the OSMA Delegation to the AMA.

REFERENCE COMMITTEES APPOINTED

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates — Homer A. Anderson, Chairman, Franklin County; Stanley J. Lucas, Hamilton County; Vincent T. La Maida, Cuyahoga County; Carl A. Minning, Clermont County; and Isador Miller, Champaign County.

Tellers and Judges of Election — Richard L. Fulton, Chairman, Franklin County; Richard J. Wiseley, Lucas County; William B. Selnick, D.O., Clermont County; George W. Petznick, Cuyahoga County; and William E. Sovik, Mahoning County.

President's Address — Thomas J. O'Grady, Chairman, Lucas County; W. J. Lewis, Montgomery County; and Frederick T. Suppes, Cuyahoga County.

Resolutions Committee No. 1 — John Kroner, Chairman, Athens County; Andrew J. Weiss, Hamilton County; John H. Taylor, Montgomery County; James Otis, Mercer County; James B. Overmier, Putnam County; Theodore J. Castele, Cuyahoga County; George H. Dietz, Mahoning County; Irving Dreyer, Jefferson County; Carl Spragg, Muskingum County; A. Burton Payne, Lawrence County; David J. Hickson, Morrow County; Jon Cooperrider, Ashland County; and W. Paul Kilway, Summit County.



LEFT TO RIGHT: John E. Moats, M.D.; Joseph L. Kloss, M.D.; William Kose, M.D.; A. Burney Huff, M.D.; M. Brodie James, M.D.; and Joseph Sudimack, Jr., M.D.

Resolutions Committee No. 2 — Stewart B. Dunsker, Chairman, Hamilton County; James M. Smith, Butler County; A. Robert Davies, Miami County; David Barr, Allen County; John A. Devany, Lucas County; Clarence L. Huggins, Cuyahoga County; Edward E. Grable, Stark County; Philip T. Doughten, Tuscarawas County; James A. Merk, Fairfield County; John Zimmerly, Jackson County; Walter M. Haynes, Jr., Franklin County; Harold F. Mills, Richland County; and Douglas M. Evans, Summit County.

Resolutions Committee No. 3 — M. Brodie James, Chairman, Lucas County; Thomas E. Fox, Warren County; Ernest Winterhoff, Clark County; William Kose, Hancock County; John E. Moats, Williams County; Bruce Andreas, Geauga County; Joseph Sudimack, Jr., Trumbull County; Norman L. Wright, Coshocton County; Robert A. Ringer, Guernsey County; Thomas P. Price, Jr., Gallia County; George W. Paulson, Franklin County; A. Burney Huff, Wayne County; and Joseph L. Kloss, Summit County.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: **First District** — Robert S. Heidt, Hamilton County; **Second District** — Isador Miller, Champaign County; **Third District** — Joseph Oppenheim, Allen County; **Fourth District** — Roland A. Gandy, Jr., Lucas County; **Fifth District** — Edward G. Kilroy, Cuyahoga County; **Sixth District** — R. J. McMahon, Jr., Stark County; **Seventh District** — Donald R. Piatt, Monroe County; **Eighth District** — John P. Anderson, Licking County; **Ninth District** — Chester H. Allen, Scioto County; **Tenth District** — Joseph A. Bonta, Franklin County; **Eleventh District** — Harold F. Mills,

(continued on page 470)

Richland County; and **Twelfth District** — Roy E. Bugay, Summit County.

Dr. Bates then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Fourth District, Dr. Roland A. Gandy, Jr., Lucas County.

INTRODUCTION OF RESOLUTIONS

Dr. Bates asked that inasmuch as the resolutions had been printed and distributed prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented in writing, the necessity to introduce them one by one be waived. No objection was voiced by the House.

Dr. Bates also announced that Resolutions 7-77, 55-77, 63-77, 70-77, and 83-77 had been withdrawn by their sponsors.

REPORT OF THE COMMITTEE ON EMERGENCY RESOLUTIONS

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met to consider three emergency resolutions: Resolution 85-77, "In Memoriam to Steven Kovacs, M.D.," by the Fifth Councilor District; Resolution 86-77, "Specialist Referral: Prerogative of Managing Physician," by Azad Katchian, M.D., President of the Belmont County Medical Society; and Resolution 87-77, regarding JCAH Standards, by the Sixth Councilor District.

Dr. John Kroner, chairman of the Committee on Emergency Resolutions, reported the committee's recommendations, as follows: Resolution No. 85-77, "In Memoriam to Steven Kovacs, M.D.," be brought to the House for immediate action. Dr. Gaughan read the resolution in its entirety. Thereupon, the House adopted the resolution by a standing vote. The text of the tribute follows:

IN MEMORIAM TO STEVEN KOVACS, M.D.

WHEREAS, The Ohio State Medical Association has lost a great friend and ardent worker due to the untimely death of Steven Kovacs, M.D., on March 24, 1977; and

WHEREAS, Doctor Kovacs, an anesthesiologist at Lakewood Hospital since 1957, distinguished himself in his profession and further, held many significant positions including President of the Medical Staff and Trustee of Lakewood Hospital, member of the Board of Directors and Secretary-Treasurer of the Academy of Medicine of Cleveland; and

WHEREAS, Doctor Kovacs served as President of the Cleveland Society of Anesthesiologists in 1965, President of the Ohio Society of Anesthesiologists in 1969, and was a member of national and international specialty societies; and

WHEREAS, Doctor Kovacs spearheaded the drive for state legislation during the 1975 malpractice insurance crisis, and was so well informed on the subject that he became a primary source of information and interpretation for the legislature; and

WHEREAS, He was almost entirely responsible for the $500,000 grant awarded to Lakewood Hospital by the Robert Wood Johnson Foundation earlier this year to establish a Primary Care Group Practice at the hospital; and

WHEREAS, He established a scholarship fund for medical students which has been of great help to three physicians now in practice and to three others presently being financed by the program; and

WHEREAS, He was active in the formation of the West Shore Medical Care Foundation, which provides in-house physician coverage in hospitals where there are no internes or residents; and

WHEREAS, Doctor Kovacs died while returning home from Columbus, where he had been testifying before the Senate Education and Health Committee on Senate Bill 130, which deals with anesthesia assistanceship; and

WHEREAS, His selfless and untiring devotion to the medical profession will be greatly missed by the many friends and colleagues whose lives he touched in so many ways; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association extend its deepest, heartfelt sympathy to the wife and family of Steven Kovacs, M.D.; and BE IT FURTHER

RESOLVED, That members of the Ohio State Medical Association wishing to offer a tribute to the memory of Doctor Steven Kovacs be encouraged to do so by contributing to the Steven Kovacs Medical Students Scholarship Fund, administered by Lakewood Hospital Foundation.

The Committee recommended that in the case of Resolution No. 86-77, "Prerogative of Managing Physician," the sponsor submit the resolution directly to the Council of OSMA for advice. The recommendation was approved.

It was recommended that Resolution No. 87-77, "The New JCAH Standards on Utilization Review," be referred to the appropriate Resolutions Committee. The House concurred.

The House voted to approve the report of the Committee on Emergency Resolutions. Resolution No. 87-77 was referred to Resolutions Committee No. 3.

HOUSE RECESSED

The House then recessed until the final session, 3:30 PM, Wednesday, May 18.



LEFT TO RIGHT: George P. Leicht, M.D.; Franklyn J. Simecek, M.D.; Richard J. Nowak, M.D.; and Donavin A. Baumgartner, Jr., M.D.

Minutes of the Second Session

The final business session of the House of Delegates convened at 3:30 PM, Wednesday, May 18, at the Sheraton-Columbus Hotel, Columbus.

Dr. Bates presented a tribute to Dr. Harold A. Meyer for 14-years' service as Commissioner of the Ohio High School Athletic Association and former Chairman of the Joint Advisory Committee OHSAA-OSMA. Dr. Meyer addressed the House and recognized the contribution of the OSMA Joint Advisory Committee on Sports Medicine to the program for Ohio high school athletes.



LEFT TO RIGHT: Harold A. Meyer, Ph.D., and Sol Maggied, M.D.

PRESENTATION OF MEDICAL JOURNALISM AWARDS

Dr. Bates presented the following Medical Journalism Awards:

Best Newspaper Article — Michael Woods, Science Editor, *Toledo Blade,* for a series on mental illness and depression.

Best Radio Broadcast — Rick Bernard, Medical Editor, WHLO Akron, for a program on microbial genetics and cancer of the bladder.

Best Television Broadcast — Marcey Goulder, Reporter, and Jerry Coleman, Photographer, for a program on sudden infant death syndrome entitled "The Empty Crib."

REPORT OF CREDENTIALS COMMITTEE

Dr. Homer A. Anderson, Columbus, Chairman of the Committee on Credentials, reported that out of 181 delegates eligible to vote, 165 were seated.

ELECTION OF PRESIDENT-ELECT

Dr. Bates called for nominations for the office of President-Elect.

Dr. John E. Albers, Cincinnati, placed in nomination Dr. Stephen P. Hogg, Cincinnati, Hamilton County, Councilor of the First District. The nomination was seconded by Dr. John A. Devany, Toledo.

Dr. P. John Robechek, Cleveland, placed in nomination Dr. John J. Gaughan, Cleveland, Cuyahoga, County, Councilor of the Fifth District. The nomination was seconded by Dr. Oscar W. Clarke, Gallipolis.

There were no other nominations. Dr. Gaughan was elected on the first ballot.



LEFT TO RIGHT: Robert G. Thomas, M.D., and John J. Gaughan, M.D.

REPORT OF NOMINATING COMMITTEE

Dr. Roland A. Gandy, Jr., Delegate, Lucas County, Chairman of the Committee on Nominations, presented the report of the Nominating Committee, as follows:

Second District: As Councilor of the Second District to succeed himself, the Committee placed in nomination Dr. W. J. Lewis, Dayton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Lewis was declared reelected Councilor of the Second District for a term of two years, 1977-1978 and 1978-1979.

Fourth District: As Councilor of the Fourth District to succeed himself, the Committee placed in nomination Dr. C. Douglass Ford, Toledo. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Ford was declared reelected Councilor of the Fourth District for a term of two years, 1977-1978 and 1978-1979.

Sixth District: As Councilor of the Sixth District to succeed himself, the Committee placed in nomination Dr. C. Edward Pichette, Youngstown. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Pichette was declared reelected Councilor of the Sixth District for a term of two years, 1977-1978 and 1978-1979.

Eighth District: As Councilor of the Eighth District to succeed himself, the Committee placed in nomination Dr. Richard E. Hartle, Lancaster. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hartle was declared reelected Councilor of the Eighth District for a term of two years, 1977-1978 and 1978-1979.

Tenth District: As Councilor of the Tenth District to succeed himself, the Committee placed in nomination

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*Withdrawn by author prior to Resolution Committee hearings.

†Passed at Opening Session of 1977 House of Delegates.

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Dr. J. Hutchison Williams, Columbus. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Williams was declared reelected Councilor of the Tenth District for a term of two years, 1977-1978 and 1978-1979.

Twelfth District: As Councilor of the Twelfth District to succeed himself, the Committee placed in nomination Dr. William Dorner, Jr., Akron. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Dorner was declared reelected Councilor of the Twelfth District for a term of two years, 1977-1978 and 1978-1979.

First District: As Councilor of the First District to serve the second year of an unexpired term, the Committee placed in nomination Dr. Stewart B. Dunsker, Cincinnati. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Dunsker was declared elected Councilor of the First District for the unexpired portion of the term (1977-1978).



Stewart B. Dunsker, M.D.

Fifth District: As Councilor of the Fifth District to succeed Dr. John J. Gaughan, Cleveland, Dr. Frederick T. Suppes nominated Dr. Theodore J. Castele, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Castele was declared elected Councilor of the Fifth District for the unexpired portion of the term of Dr. Gaughan (1977-1978).

AMA Delegates: Dr. Gandy then presented the nominees for the office of Delegate to the American Medical Association for a term of two years beginning January 1, 1978: Drs. John E. Albers, Cincinnati; George N. Bates, Toledo; Oscar W. Clarke, Gallipolis; Henry A. Crawford, Cleveland; Harry K. Hines, Cincinnati; W. J. Lewis, Dayton; and P. John Robechek, Cleveland. The nominations were duly seconded, and there were no further nominations from the floor. A secret ballot was taken; and Drs. Albers, Bates, Clarke, Lewis, and Robechek were declared elected.

AMA Alternate Delegates: For Alternate Delegates to the American Medical Association for a term of two years beginning January 1, 1978, the Nominating Committee placed in nomination the names of Drs. Theodore J. Castele, Cleveland; Robert R. Clark, Akron; Henry A. Crawford, Cleveland; C. Douglass Ford, Toledo; Thomas E. Fox, Mason; Richard L. Fulton, Columbus; John J. Gaughan, Cleveland; Edward E. Grable, Canton; Harry K. Hines, Cincinnati; and William J. Schrimpf, Cincinnati. Drs. Crawford and Hines declined the nomination. The nominations were duly seconded, and there were no further nominations from the floor. A secret ballot was taken; and Drs. Castele, Ford, Fulton, Gaughan, and Grable were declared elected.

For the one-year term to fill the vacancy created by Dr. Albers' election as Delegate, Drs. Joseph A. Bonta, Columbus; Thomas E. Fox, Mason; and Frederick T. Suppes, Cleveland, were nominated. The nominations were duly seconded, and there were no further nominations from the floor. Dr. Fox was elected Alternate Delegate for a term beginning January 1, 1978 and ending December 31, 1978.

Committee on President's Address

Dr. Bates then called for the report of the Reference Committee on President's Address (See text of address in this issue.), which was presented by Dr. Thomas J. O'Grady, Lucas County, Chairman of the Committee. The report read as follows:

The Committee congratulates Dr. Bates on his address, delivered with courage and clarity, which placed in perspective the socio-economic and regulatory challenges now facing us.

In exhorting this House of Delegates to respond "not with a sense of ending, but a sense of beginning," he amplified on the mutual interdependence of the individual physician, the OSMA and the AMA. The emphasis was directed at increasing our collective, representative voice by supporting and expanding AMA participation. The problems of a dwindling membership together with criticisms of the federation structure were not minimized, but highlighted with an appeal to this organization to consider seriously working toward modifications which will culminate in a stronger parent organization more responsive to the needs of the profession. The clarion was clearly sounded that our troubles are not in Chicago, but rather in Washington, our State Legislatures and local Health Systems Agencies, demanding constant vigilance and input at all levels.



LEFT TO RIGHT: Frederick T. Suppes, M.D.; Edward G. Kilroy, M.D.; and Theodore J. Castele, M.D.



LEFT TO RIGHT: John E. Moats, M.D.; Roland A. Gandy, Jr., M.D.; Thomas J. O'Grady, M.D.; and C. Douglass Ford, M.D.

Attention was carefully focused on emerging intramural responsibilities and concerns as well. The suggestion was proffered that the Council balance immediate objectives and long-range goals and establish priorities. The House of Delegates was challenged to develop a better methodology for the submission and adoption of resolutions in order to keep tempo with times that have become litigious!

There was some guarded reassurance for the membership in Dr. Bates' remarks concerning the slow, incremental implementation of a comprehensive government health plan. He incisively observed that our collaboration in slowing the escalation of health care cost might be one efficient method for delaying National Health Insurance further. His economic overview honed in on the lack of cost consciousness brought about by first dollar insurance coverage as the rationale for our possible advocacy of cost-sharing by patients, variable cost health insurance, health planning, HMO's and Individual Practice Associations.

Permeating the text of this Address are a series of accomplishments registered by the OSMA during the past year, not the least of which are the establishment of PICO and a number of legislative triumphs. Obviously, these cannot be attributed to the industry of one individual. However, if one person should be singled out and credited for his efforts in these endeavors, it must be George Bates whose Presidential actions have spoken more loudly and will continue to impact more far-reachingly than any of the words that were so well chosen and well delivered this Sunday evening, past. It is with this in mind that our Committee, speaking for the House of Delegates, tenders not only its congratulations for being such an able, articulate spokesman on our behalf, but also its heartfelt gratitude for such a productive stewardship!

On a motion made and seconded, the House of Delegates, by official action, approved the report of the Reference Committee on President's Address.

Report of Resolutions Committee No. 1

Dr. John F. Kroner, Athens County, reported for Resolutions Committee No. 1, of which he was Chairman. The report is as follows:

RESOLUTION NO. 1-77
Proposed Amendment to the Bylaws to Define Valid Ballots in Elections

The majority of testimony heard by the Committee was against this resolution. The Committee felt that the current method of voting is as fair a way as we could devise.

Therefore, Mr. President, the Committee recommends that Resolution No. 1-77 be **NOT** adopted and I so move.

By official action, the House voted to reject Resolution No. 1-77.

RESOLUTION NO. 2-77
Appointment Procedures for Committees for this Association

The Committee considered Resolution No. 2-77 and amends the resolution. After discussion, the Committee wished to point out to the whole House that under the amended resolution, the term of appointment will be changed, the fixed number of members will change, and the method of ratification of appointments and detailed purposes of each committee will be changed as prescribed by Council.

The amended resolution is as follows:

Amended Resolution No. 2-77

WHEREAS, With the expansion of medical science and technology, as well as the many different facets which affect medicine; and

WHEREAS, The Bylaws of the Association were developed many years ago not taking into consideration that the necessity to establish many more committees would be necessary; and

WHEREAS, Upon several occasions some deletions and additions have been made in the number of standing committees; and

WHEREAS, Even though there are five (5) such committees there are a number of special committees which are as significant to the medical science and technology of the Association as the standing committees; and

WHEREAS, There is no provision in the Bylaws to replace a member who is not active and fails to participate within that five (5) year appointment; NOW, THEREFORE, BE IT RESOLVED, That Chapter 9 of the current Bylaws be deleted and a new Chapter 9 be substituted as follows:

"Chapter 9
Committees

Section 1. Titles of Committees. The standing committees of this Association shall be the following:

1. Committee on Public Relations, 2. Committee on Scientific Work, 3. Committee on Education, 4. Committee on Judicial and Professional Relations, and 5. Committee on Membership and Planning.

Other committees of this Association shall be those designated in Sections 4 and 7 of Chapter 4; Section 1 of Chapter 5 and Section 5 of Chapter 7, and such special committees as may be appointed by the president.

Section 2. Appointment. The President with approval of Council shall appoint the chairman and members of each committee. Each appointment shall be for a term of two years, except for the first appointments when one-half of the committee shall be for one year and one-half of the committee shall be for two years, to assure an efficient transition and continuity of committee objectives. If a vacancy occurs, the president with approval of Council, would fill the vacancy for the remainder of the term.

Section 3. Duties and Responsibilities of Committees. Each standing and special committee shall consider all items referred thereto by the House of Delegates and the Council. The purpose(s) of each committee shall be prescribed by the Council.

The actions of all standing and special committees shall be subject to the approval of the Council."

Mr. President, the Committee recommends adoption of Amended Resolution No. 2-77 and I so move.

By official action, the House voted to adopt **Amended Resolution No. 2-77.**

RESOLUTION NO 3-77
Creation of House Officers Section

After much discussion, the Committee feels the title of Resolution No. 3-77 should be changed to "Creation of Resident Physicians Section," and presents the following amended resolution:

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House of Delegates' Proceedings

Amended Resolution No. 3-77

WHEREAS, Postgraduate medical students in the State of Ohio have a genuine vested interest in the business of organized medicine within this state and the nation; and

WHEREAS, The need for solidarity within the medical profession is ever increasing as numerous special interest groups and governmental agencies continue the assault on the physician-patient relationship; and

WHEREAS: The AMA formed an Intern/Resident Business Session in 1972 giving House Officers voting positions on all major AMA policy boards and a voting delegate to the House of Delegates; NOW, THEREFORE, BE IT

RESOLVED, That the President of the Ohio State Medical Association appoint a committee to determine the appropriate organization and necessary changes to the Ohio State Medical Association Constitution and Bylaws to create a Resident Physician Section; and BE IT FURTHER

RESOLVED, That the committee report to the Ohio State Medical Association House of Delegates at the next session the recommended organization and changes to the Ohio State Medical Association Constitution and Bylaws to create a Resident Physician Section.

Therefore, Mr. President, the Committee recommends Amended Resolution No. 3-77 be adopted and I so move.

By official action, the House **voted to adopt Amended Resolution No. 3-77, with one editorial change.**

RESOLUTION NO. 4-77
Delegate Representation for Small Counties

After testimony and much discussion in executive session, the Committee felt that this resolution may create new problems.

Therefore, Mr. President, the Committee recommends Resolution No. 4-77 **NOT** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 4-77.**

AMENDED RESOLUTION NO. 5-77
Special Meetings of OSMA

After discussion, the Committee felt the "RESOLVED" of Resolution No. 5-77 should be amended as follows:

WHEREAS, Article V, Section 3 of the Constitution of the OSMA presently allows a special meeting of the House of Delegates upon a 'petition duly authorized and signed by the governing bodies of at least thirty (30) component societies'; and

WHEREAS, The term 'governing bodies' is unclear; and

WHEREAS, The requirement of a minimum of thirty (30) component societies effectively precludes the possibility of a special meeting of the House of Delegates of OSMA by the petition method; THEREFORE, BE IT



LEFT TO RIGHT: Stephen P. Hogg, M.D.; John E. Albers, M.D.; H. William Porterfield, M.D.; and Richard L. Fulton, M.D.



LEFT TO RIGHT: John Kroner, M.D.; John H. Taylor, M.D.; George H. Dietz, M.D.; James Otis, M.D.; and Andrew J. Weiss, M.D.

RESOLVED, That Article V, Section 3, of the OSMA Constitution be amended to permit the calling of a special meeting of the House of Delegates of OSMA upon a petition duly authorized and signed by the presidents of at least twenty-three (23) component societies.

Mr. President, the Committee recommends the adoption of this Amended Resolution No. 5-77 and I so move.

By official action, the House **voted to adopt Amended Resolution No. 5-77.**

RESOLUTION NO. 6-77
Semi-Annual Sessions of the House of Delegates

After much discussion, the projected cost of $20,000 did not seem to be practical.

Therefore, the Committee recommends that Resolution 6-77 be **NOT** adopted and I so move.

By official action, the House **voted to reject Resolution No. 6-77.**

RESOLUTIONS NO. 8-77 and 10-77
Unified Membership and AMA Membership

The Committee considered Resolutions No. 8-77 and 10-77 together and presents the following Substitute Resolution:

Substitute Resolution No. 8-77

WHEREAS, The federation concept of representing the interest of physicians through a unified national movement must be addressed seriously at all levels of the federation in the immediate future; and

WHEREAS, The American Medical Association is the only medical organization that can serve as the official spokesman for all physicians on national issues; and

WHEREAS, The American Medical Association provides its services to all state medical associations on an equal basis without regard to the number of state members who support the American Medical Association through membership; and

WHEREAS, The American Medical Association is dedicated to acting in the best interest of all physicians and in promoting highest quality medical care for all patients; NOW, THEREFORE, BE IT

RESOLVED, That the President of the Ohio State Medical Association with the approval of Council appoint a broad-

based committee to study the feasibility *AND ADVISABILITY* of establishing the unified membership concept in Ohio and, BE IT FURTHER

RESOLVED, That the Committee report its findings to the Ohio State Medical Association House of Delegates at the Annual Meeting in 1978.

Mr. President, the Committee recommends adoption of Substitute Resolution No. 8-77 and I so move.

By official action, the House **voted to adopt Substitute Resolution No. 8-77, with one addition, as set forth in capital letters.**

RESOLUTION NO. 9-77
To Establish the Offices of Speaker and Vice Speaker of the House of Delegates of the OSMA

After discussion, the Committee was not in favor of Resolution No. 9-77 and recommends that the resolution be **NOT** adopted, and Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 9-77.**

RESOLUTION NO. 11-77
Freedom for All

The principles embodied in this resolution are of importance but the resolution is somewhat vague and needs more concrete, workable proposals.

Therefore, the Committee recommends that Resolution No. 11-77 **NOT** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 11-77.**



David J. Hickson, M.D.

RESOLUTION NO. 12-77
When Free Men Shall Stand

After discussion, again the Committee felt that the resolution contained merit and substance but felt that it would establish a precedent. The Committee felt this is an action which could be taken privately by those interested.

Therefore, Mr. President, the Committee recommends that the Resolution No. 12-77 **NOT** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 12-77.**

RESOLUTIONS NO. 13-77, 19-77 and 24-77
National Health Insurance

The testimony of over one hour favored health insurance of the following type (1) Voluntary on the part of the patient, (2) Purchased through the private sector, (3) An indemnity type, (4) A schedule of benefits for the patients (not a fee schedule for the doctor), (5) Free choice of physician, and (6) Government involvement be limited to the purchase of insurance for the indigent and the elderly.

Since the AMA bill is based on these elements as well as others, and is not a national health service but a comprehensive medical benefits plan, therefore, the Committee believes the AMA bill should satisfy those testifying before the Committee and recommends that Resolutions No. 13-77, 19-77 and 24-77 be **NOT** adopted and I so move.

By official action, the House **voted to reject Resolutions No. 13-77, 19-77, and 24-77.**

RESOLUTIONS NO. 14-77 and 25-77
Relative Value Schedules

The Committee discussed Resolutions No. 14-77 and 25-77 and wished to combine them as follows:

Substitute Resolution No. 14-77
Relative Value Scales

WHEREAS, The governmental agencies such as Medicare and Medicaid, Department of Public Welfare, as well as insurance companies rely upon relative value scales for physicians, and

WHEREAS, Relative Value Scales have simplified third party payments to physicians, increasing efficiency and lowering costs; and

WHEREAS, The Federal Trade Commission of our government has seen fit ~~in all its wisdom~~ to challenge this relative value scale ~~for the~~ *WHEN USED AS GUIDELINES BY* physicians as being improper, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association takes the position that relative value scales do not impair or restrain competition in the medical profession, and BE IT FURTHER

RESOLVED, That the OSMA indicate its support of the AMA's efforts in appealing to the Congress to pass whatever legislation is necessary to permit use of relative value scales by the physician.

Mr. President, the Committee recommends adoption of Substitute Resolution No. 14-77 and I so move.

By official action, the House **voted to amend Substitute Resolution No. 14-77 as indicated by the strike-out deletions and by the addition set forth in capital letters, then adopted it.**

RESOLUTIONS NO. 15-77 and 17-77
HEW Provider Agreement

The Committee discussed Resolutions 15-77 and 17-77,

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dealing with the Medicaid Provider Agreement. Testimony was heard to the effect that upon signing the provider agreement for the Ohio Department of Public Welfare, that you thus permit your records on all of your patients, both public and private, to be examined by the ODPW at its discretion for the purposes of comparison of fees and services.

The Committee feels the resolutions should be combined into the following Substitute Resolution:

Substitute Resolution No. 15-77

WHEREAS, The physicians of Ohio have protested the "Provider Agreement" for Medicaid patients required by the Ohio Department of Public Welfare without satisfactory outcome, and

WHEREAS, The wording of the agreement pretends a deliberate attempt of physicians to discriminate in their practice, which is farthest from the truth; and

WHEREAS, The provider agreement required by the Ohio Department of Public Welfare pursuant to provisions of Title 19 and the consequences of the provider agreement have not been fully understood by the members of the Association, NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association pursue a vigorous education campaign through its publications and other means to inform its membership fully of the provisions and the application of Title 19 and the provider agreement to the member's own private practice/ AND BE *IT FURTHER*

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION REQUEST THE AMERICAN MEDICAL ASSOCIATION TO INTRODUCE AND SUPPORT LEGISLATION IN CONGRESS TO REMOVE THE USE OF A "PROVIDER AGREEMENT" AS A REQUIREMENT FOR PARTICIPATION UNDER MEDICAID.

Mr. President, the Committee recommends that Substitute Resolution No. 15-77 be adopted and I so move.

By official action, the House **voted to amend Substitute Resolution No. 15-77 as indicated by the additions set forth in capital letters, then adopted it.**

RESOLUTION NO. 18-77
To Form a Joint Committee to Investigate Federal Regionalism

Testimony at the Committee hearings showed that there already had been introduced in the Legislature HJR (33) encompassing much of the intent of this resolution. Therefore, this resolution has become moot.

We therefore recommend that Resolution No. 18-77 **NOT** be adopted and Mr. President, I so move.



LEFT TO RIGHT: Carl Spragg, M.D.; Richard E. Hartle, M.D.; and William E. Sovik, M.D.

By official action, the House **voted to reject Resolution No. 18-77.**

RESOLUTION NO. 20-77
P.S.R.O. Repeal

The theme of this resolution is the same as that of Resolution No. 25-76, as amended in the House of Delegates in 1976.

Therefore, we recommend that this Resolution No. 20-77 **NOT** be adopted.

By official action, the House **voted to reject Resolution No. 20-77.**



CLOCKWISE (beginning with speaker): Nino M. Camardese, M.D.; J. James Anderson, M.D.; William Dorner, Jr., M.D.; Joseph McKell, M.D.; and Frederic C. Schnebly, M.D.

RESOLUTION NO. 21-77
Federal Government Encroachment

During testimony it was brought out that there are five similar functioning organizations already in existence and that formation of a new organization is not needed at this time.

Therefore, we recommend that this Resolution No. 21-77 **NOT** be adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 21-77.**

RESOLUTIONS NO. 22-77 AND 27-77
Title 19 (Medicaid)

After much discussion, the Committee felt that Resolution No. 22-77 and Resolution No. 27-77 should be combined into one Substitute Resolution as follows:

Substitute Resolution No. 22-77

WHEREAS, The original intent of Title 19 (Medicaid) of the Medicare Act of 1965 was that Public Assistance Recipients should receive medical care and services of the same quality and under the same circumstances as other members of the community who pay for care from their own resources (Dept. HEW Nov. 1966); and

WHEREAS, Charity medicine is being abandoned in favor of new public programs which give needy the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens (HEW Feb. 1967); and

WHEREAS, The State of Ohio, *AS WELL AS OTHER STATES,* is currently failing to carry out the original intent of Title 19 by refusing adequate financial assistance to Medicaid recipients; and

WHEREAS, The arbitrary fee schedule of the Department of Welfare pays in ~~many~~ *MOST* instances only a small fraction of the physician's usual, customary and reasonable fee, thus

reverting back to 'charity medicine' on the part of the practitioner who cares for these patients and 'charity circumstances' on the part of the indigent patients; and

WHEREAS, With increasing malpractice premiums and other overhead expenses this unreasonable and totally inadequate program has forced many patients into the demeaning position of seeking their care on a charity basis, thereby abrogating the original intent of Title 19; NOW, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association support legislation to amend Title 19 to permit physicians the same billing options as provided in Title 18 of the Social Security Act; and BE IT FURTHER

RESOLVED, That this resolution be introduced as an Ohio resolution at the next convention of the AMA*, IN JUNE 1977; AND BE IT FURTHER*

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION SUPPORT LEGISLATION TO AMEND THE APPLICATION OF TITLE 19 SO THAT THE ARBITRARY FEE SCHEDULE OF THE DEPARTMENT OF WELFARE PAY THE PHYSICIANS THEIR USUAL, CUSTOMARY AND REASONABLE FEE.

The Committee recommends the adoption of Substitute Resolution No. 22-77 and, Mr. President, I so move.

By official action, the House voted to amend Substitute Resolution No. 22-77 as indicated by the strike-out deletions and by the additions set forth in capital letters, then adopted it.

RESOLUTIONS NO. 23-77 and 26-77
Cost Containment; Government Health Programs

The Committee considered Resolutions No. 23-77 and 26-77 together and offers the following Substitute Resolution:

Substitute Resolution No. 23-77

WHEREAS, Ohio physicians are deeply concerned about the rapidly increasing costs of health care; and

WHEREAS, We believe that a substantial component of this inflation is generated by government health programs and other third party programs, THEREFORE, BE IT

~~RESOLVED, That the Ohio State Medical Association recommend to all insurance carriers, be they public or private, the phasing out of full coverage contracts with fixed limits in substitution for indemnity contracts with a schedule of benefits and first dollar participation by the insureds.~~

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION RECOMMEND TO ALL INSURANCE CARRIERS, BOTH PUBLIC AND PRIVATE, THAT SUCH CARRIERS PROMOTE AND SELL CONTRACTS EMPHASIZING INDIVIDUAL PATIENT RESPONSIBILITY INCLUDING DEDUCTIBLES AND CO-INSURANCE RATHER THAN 'FIRST DOLLAR COVERAGE AND/OR PAID-IN-FULL CONTRACTS' WHICH INSULATE THE PATIENT COMPLETELY FROM CONSIDERATION OF COSTS.

Therefore, the Committee recommends adoption of Substitute Resolution 23-77 and, Mr. President, I so move.

By official action, the House voted to amend Substitute Resolution No. 23-77 as indicated by the strike-out deletions and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 28-77
Advertising Ethics

The Committee considered Resolution No. 28-77 and felt it should be amended as follows:

Amended Resolution No. 28-77

WHEREAS, Advertising has become a crucial issue in the area of medical professional ethics, NOW, THEREFORE, BE IT

RESOLVED, That Council be directed to investigate the problems related to ethics in advertising and that Council be directed to study the recent publication of the AMA, *Judicial Council Opinions and Reports,* pertaining to ethical problems in advertising in order to develop a mechanism useful within the state and at the local level.

Mr. President, the Committee recommends adoption of Amended Resolution No. 28-77 and I so move.

By official action, the House voted to adopt Amended Resolution No. 28-77.

RESOLUTION NO. 29-77
Uniform State Health Agency Forms

During testimony evidence was given where various state health agencies, in addition to requiring their own forms, even require specific typewriters and ink for completing their forms. This creates undue burden upon the physician and his staff and we believe that Resolution No. 29-77 should be adopted and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The various State Agencies participating in Health Care Services require a multiplicity of forms for billing and reporting; and

WHEREAS, These forms are changed frequently, producing confusion and wasted time in physicians' offices; and

WHEREAS, Different coding systems are required by different agencies; THEREFORE, BE IT

RESOLVED, That the OSMA recommend that all State Agencies involved in funding health care consolidate forms in a uniform manner and with a uniform code system and that consideration of changes in forms be reviewed in consultation with the OSMA before any change is implemented.

By official action, the House voted to adopt Resolution No. 29-77.



LEFT TO RIGHT: Carl A. Lincke, M.D.; Sanford J. Press, M.D.; and George W. Petznick, M.D.

RESOLUTION NO. 16-77
H.R. 3 — Unconstitutional Search and Seizure

Testimony on this resolution revealed that the "shared health facility" portion of the H.R. 3 has already been removed from the proposed legislation making this resolution unnecessary. The Committee does wish, however, to officially commend OSMA President Dr. Bates for his timely and effective letter of objection to the proposed bill.

(continued on page 480)

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The Committee, therefore, recommends that Resolution No. 16-77 be NOT adopted and I so move.

By official action, the House **voted to reject Resolution No. 16-77**

The report of Resolutions Committee No. 1, as a whole, as amended, was approved by the House.



LEFT TO RIGHT: Stewart B. Dunsker, M.D.; Harold F. Mills, M.D.; Philip T. Doughten, M.D.; James A. Merk, M.D.; John Zimmerly, M.D.; David Barr, M.D.; John A. Devany, M.D.; and Clarence L. Huggins, M.D.

Report of Resolutions Committee No. 2

Dr. Stewart B. Dunsker, Hamilton County, reported for Resolutions Committee No. 2, of which he was Chairman. The report is as follows:

RESOLUTION NO. 30-77
Liability Reform

The first resolution to be considered was Resolution No. 30-77. This resolution deals with many of the liability problems which confront physicians throughout the state. It was written before the Governor's Advisory Commission on Malpractice Report was available and many of the items proposed in the original resolution were discussed in depth in that report and appropriate recommendations were made. In some cases, these recommendations of the Advisory Commission Report differ from the exact wording in the original resolution. However, the intent was the same. Resolutions Committee No. 2, in most cases, was in favor of the r commendations of the Advisory Commission.

Some of the items in the original resolution were deliberated by this House of Delegates in previous years. Other items, although desirable to the physicians of Ohio, have not been accomplished in spite of extreme diligence and conscientious effort by the Council of the OSMA and its staff. Some of these particulars remain of great concern to physicians.

In the opinion of a legal consultant to the Resolutions Committee, the objectives of the portion of the original resolution patterned after the New York informed consent law are already met by the current case law of the State of Ohio.

Amended Substitute Resolution No. 6-76 requested the OSMA Council to develop and to support legislation to permit legal redress for physicians wrongly and unjustly sued, including repayment of defense costs and facilitation of mechanisms for counterclaims. In spite of a lack of success to date, the Council has continued to work towards these ends.

Therefore, the following substitute resolution is proposed:

Substitute Resolution No. 30-77
Liability Reform

WHEREAS, The passage of House Bill 682 was an initial effort to provide some degree of legislative relief for the medical professional liability crisis in Ohio; and

WHEREAS, It is recognized that additional legislation is needed to modify certain provisions contained in the legislation; and

WHEREAS, Additional legislation should be sought to provide an alternative to a lump-sum award, which arises out of an action for medical professional liability, and which is frequently not based on the present and future needs, or disability of the claimant; and

WHEREAS, Information relative to the amount and type of insurance carried by a defendant in a civil action is discoverable under the rules of civil procedure in the State of Ohio, the access to which constitutes an invasion of the privacy of the defendant; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability continue to encourage and support legislation to:

1. Place limits on the amount of contribution any one physician or corporation, including those insured by companies other than the Joint Underwriting Association (JUA), is required to pay to the Stabilization Reserve Fund to three consecutive or non-consecutive annual contributions.
2. Amend the Ohio Revised Code to permit periodic payments based on the present and future disability of an individual as an alternative to lump-sum awards.
3. Prevent the discovery of the amount and type of liability insurance carried by an individual or corporation named as a defendant in a civil action; and, *BE IT FURTHER*

RESOLVED, THAT THE OHIO STATE MEDICAL ASSOCIATION SUPPORT THE MAJOR THRUST OF THE RECOMMENDATIONS OF THE MAJORITY REPORT OF THE GOVERNOR'S ADVISORY COMMISSION ON MALPRACTICE; and, BE IT FURTHER

RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability report its progress on these issues to the House of Delegates at the next Annual Meeting.

Mr. President, I move the adoption of Substitute Resolution No. 30-77.

By official action, the House **voted to amend Substitute Resolution No. 30-77 as indicated by the additions set forth in capital letters, then adopted it.**

RESOLUTIONS NO. 31-77 and 45-77
Informed Consent and
Amendment of Section 2317.54 Ohio Revised Code

Resolutions No. 31-77 and 45-77 were considered together. Subsequent to the introduction of these resolutions, physicians of Ohio were informed of Amended House Bill No. 213 which was introduced to the 112th General Assembly upon the recommendation of the Ohio State Medical Association. This bill, if enacted into law, will satisfy the goals of these two resolutions. Therefore, the Committee recommends that Resolutions No. 31-77 and 45-77 **not** be adopted, and I so move.

By official action, the House **voted to reject Resolutions No. 31-77 and 45-77.**

RESOLUTION NO. 32-77
Umbrella

The Committee next discussed Resolution No. 32-77 and, after due consideration, unanimously recommended the adoption of the resolution, and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, Demands and awards in the field of professional liability have been escalating; and

WHEREAS, There is a need for protection beyond that provided by basic coverage offered by PICO; and

WHEREAS, The Physicians Insurance Company of Ohio has recognized the need to provide coverage over and above



LEFT TO RIGHT: A. Burney Huff, M.D.; S. Baird Pfahl, M.D.; Delbert L. Fischer, M.D.; Richard W. Avery, M.D.; and James W. Wiggin, M.D.

what is currently being offered; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association commend PICO for its efforts to develop a program to provide excess (umbrella) coverage to the physicians of Ohio at the earliest possible time and that PICO be encouraged to continue this effort.

By official action, the House **voted to adopt Resolution No. 32-77.**

RESOLUTIONS NO. 33-77 and 46-77
Sliding Scale and Medical Liability Insurance Premiums— Relating to Physicians Planning to Retire or Retired

The next two resolutions to be considered together were Resolutions No. 33-77 and 46-77. After much discussion, the Committee voted to recommend the following substitute resolution:

Substitute Resolution No. 33-77
Sliding Scale

WHEREAS, The present cost of medical liability insurance is high; and

WHEREAS, Resolution No. 30-76, calling for a petition to the Joint Underwriting Association for the development of a sliding scale of premiums for beginning, retiring, and part-time practitioners of medicine, was adopted by the House of Delegates of the Ohio State Medical Association; and

WHEREAS, The Ohio State Medical Association has formed the Physicians Insurance Company of Ohio (PICO); THEREFORE BE IT

RESOLVED, That the Council of the Ohio State Medical Association indicate to the Joint Underwriting Association and to the Physicians Insurance Company of Ohio (PICO) our interest in the development of a program of a sliding scale of premiums related to income for beginning, retiring, part-time, and retired practitioners of medicine.

Mr. President, I move the adoption of Substitute Resolution No. 33-77.

By official action, the House **voted to adopt Substitute Resolution No. 33-77.**

RESOLUTION NO. 34-77
Contingency Fees

There is conflicting evidence whether or not reduction of attorneys' contingency fees in medical malpractice cases will decrease the incidence of these suits. Moreover, the Ohio State Medical Association Task Force on Professional Liability has tried, without success, to get the Ohio Supreme Court to regulate and limit these fees. Therefore, the Committtee voted to amend Resolution No. 34-77 as follows:

Amended Resolution No. 34-77

WHEREAS, In the formation of House Bill 682, the review of contingency fees was referred to the Ohio Supreme Court; and

WHEREAS, Other states have placed regulations and limitations upon contingency fees; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability continue to urge and/or petition the Ohio Supreme Court to apply reasonable limits on contingency fees in all tort actions.

Mr. President, I move the adoption of Amended Resolution No. 34-77.

By official action, the House **voted to adopt Resolution No. 34-77.**

RESOLUTION NO. 35-77
Itemization of Awards

The Committee was informed by a legal consultant that juries and arbitration panels often itemize awards now before they present their report or return their verdict to the court. In addition, requiring the itemization of awards often distracts the juries and arbitration panels from considering the more important issue of whether or not a defendant is or is not legally liable to the claimant in a medical malpractice case. Therefore, I move that Resolution No. 35-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 35-77.**

RESOLUTION NO. 36-77
Impartial Arbitration

The next resolution to be considered was Resolution No. 36-77. The Committee recommended that this resolution be adopted and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, In May of 1976, the Ohio State Medical Association House of Delegates approved amended Resolution 20-76; and

WHEREAS, The need to assure that the members of any arbitration board shall be competent and disinterested remains a vital concern to all physicians; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reaffirm amended Resolution 20-76 which stated:

"RESOLVED, That the Ohio State Medical Association Council shall continue to study the method by which arbitrators are selected and devise a method of selection to assure that all members of the arbitration board shall be competent, disinterested parties."

By official action, the House **voted to adopt Resolution No. 36-77.**

RESOLUTIONS NO. 37-77 and 52-77
JUA to Offer an Occurrence Contract and JUA to Issue Occurrence Insurance Contracts

Resolutions No. 37-77 and 52-77 were considered together. It was the consensus of the Committee that Resolution No. 37-77 stated the intent of both resolutions more concisely and will serve as a combined resolution. Therefore, Mr. President, I move the adoption of Resolution No. 37-77.

The resolution reads as follows:

Resolution No. 37-77

WHEREAS, The Ohio State Medical Association House of Dele-

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gates at their Annual Meeting in 1976 adopted amended Resolution 18-76; and

WHEREAS, It is still the belief of the physicians in the State of Ohio that it is desirable for a physician to pay the full cost of his professional liability insurance during a period of economic productivity rather than to require payments when income is no longer being earned; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reaffirm its support of amended Resolution 18-76 which stated:

"RESOLVED, That the Ohio State Medical Association Council shall prepare and sponsor legislation to require that the Ohio Medical Professional Liability Insurance Underwriting Association offer an occurrence contract to its policyholders."

By official action, the House **voted to adopt Resolution No. 37-77.**

RESOLUTION NO. 38-77
Definition of Negligence

A legal consultant advised the Committee that Ohio case law already recognizes that the choosing of any form of therapy from among several recognized forms is a matter of medical judgment and is not evidence of professional negligence. Moreover, present case law already distinguishes malpractice from maloccurrence. The Resolutions Committee does not believe that Resolution No. 38-77 will improve the current law. Therefore, Mr. President, I move that this resolution **not** be adopted.

By official action, the House **voted to reject Resolution No. 38-77.**



LEFT TO RIGHT: Harry K. Hines, M.D.; Thomas E. Fox, M.D.; and Robert J. Hasl, M.D.

RESOLUTION NO. 39-77
Expert Witness

The intent of this resolution was to insure that plaintiffs' expert witnesses be familiar with standards of care applying in the geographical area in which action is being litigated. It was also intended to prevent the use of questionable expert witnesses who sell their testimony to the highest bidder. In spite of those admirable intentions, the Committee was informed that sometimes expert testimony from witnesses residing in distant states is required by both plaintiffs and defendants. I therefore move that this resolution **not** be adopted.

By official action, the House **voted to reject Resolution No. 39-77.**

RESOLUTION NO. 40-77
Insurance Data

New requirements under Ohio law provide that each insurance company file with the Ohio Department of Insurance the information listed in the resolution. Because the goals of this resolution are already fulfilled, I recommend that Resolution No. 40-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 40-77.**

RESOLUTION NO. 41-77
Notice of Intention to File Suit

Considerable testimony regarding Resolution No. 41-77 was heard in open and closed session. There is no evidence that prior notice of intention to file suit leads to amicable settlement of claims before suits are filed. Moreover, Ohio Revised Code Section 2305.11, Paragraph A, already extends the statute of limitations 180 days. Although it is the intent of this resolution that a notice of intent to file suit be given 60 days prior to the actual filing of each suit, Ohio State Medical Association legal counsel advised the Committee that it will only serve to extend the statute of limitations an additional 60 days. Mr. President, I therefore move that this resolution **not** be adopted.

By official action, the House **voted to reject Resolution No. 41-77.**

RESOLUTIONS NO. 42-77 and 51-77
Statute of Limitations

The intention of these two resolutions is to absolutely limit the statute of limitations to one year from the date that an incident or event for which a malpractice claim is initiated. Legal consultation indicated that Ohio law already approaches that goal. A survey of the statutes of limitations in all other states reveals that the Ohio statute of limitations, with respect to physicians and hospitals, is one of the most favorable in the country. Efforts are being made by other interested parties to lengthen the Ohio statute of limitations. Therefore, it is recommended that no changes be sought by the OSMA in the Ohio statute of limitations; and, Mr. President, I move that Resolutions No. 42-77 and 51-77 **not** be adopted.

By official action, the House **voted that Resolutions No. 42-77 and 51-77 be referred to the OSMA Task Force on Professional Liability.**

RESOLUTIONS NO. 43-77 and 50-77
PICO and Professional Liability Insurance

Resolutions No. 43-77 and 50-77 were considered together. Considerable testimony was heard from delegates, physicians, and members of the Board of Directors of the Physicians Insurance Company of Ohio and some of its officers. The Resolutions Committee was convinced that the Physicians Insurance Company of Ohio is capable of providing lines of property and casualty insurance without incurring significant additional expenses. Moreover, the management of the company has the expertise and ability to generate profits on these additional lines of insurance which can only add to the financial stability of the company. Because the Physicians Insurance Company of Ohio is authorized to sell all lines of property and casualty insurance and, if possible, make a profit, it is advisable that the company enter insurance markets other than that of medical malpractice.

The Committee was assured by management of PICO that auditing and reporting data related to the malpractice function will be maintained separately.

Therefore, Mr. President, I move that Resolutions No. 43-77 and 50-77 **not** be adopted.

By official action, the House **voted to reject Resolutions No. 43-77 and 50-77.**



LEFT TO RIGHT: Frederic C. Schnebly, M.D.; Richard G. Jenkins, M.D.; W. J. Lewis, M.D.; and Henry Diederichs, M.D.

RESOLUTION NO. 44-77
Professional Liability Investigative Fund

The intent of this resolution was completely fulfilled by the recently released Report of the Task Force on Professional Liability of the OSMA. Therefore, I move that Resolution No. 44-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 44-77.**

RESOLUTION NO. 47-77
PICO Classification Changes

The goal of Resolution No. 47-77 is to offer financial relief for physicians who, though highly qualified, perform certain high-risk procedures or fulfill certain high-risk functions infrequently. Expert testimony revealed that it is not possible to make a general rule that would apply to all physicians under any circumstances. However, any physician insured by the Physicians Insurance Company of Ohio (PICO), who believes he has been given the wrong liability insurance classification, has the right of individual appeal. This individual appeal has been used in the past by the governing board of PICO to consider the specific needs of both physicians and the areas in which they practice. Therefore, I move that Resolution No. 47-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 47-77.**

RESOLUTION NO. 48-77
Commendation for the Professional Liability Committee

After reviewing Resolution No. 48-77, the Commmittee unanimously agreed that this resolution should be adopted, and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The availability of medical liability insurance at affordable rates has continued to be a serious problem; and
WHEREAS, Private insurance companies and the Joint Underwriting Authority have tried to escalate these rates without justification; and
WHEREAS, The Professional Liability Committee evaluated the possibility and rationale for forming a physician-owned insurance company and reported on it so promptly and thoroughly that it could be voted upon by the House of Delegates and brought to fruition in a minimum amount of time; THEREFORE, BE IT
RESOLVED, That the Ohio State Medical Association officially commend The Professional Liability Committee, chaired by James L. Henry, M.D., for their outstanding work.

By official action, the House **voted to adopt Resolution No. 48-77.**

RESOLUTION NO. 49-77
Information Requested on a Physician's Application for Hospital Privileges in Community Hospitals

After a discussion of Resolution No. 49-77, the Committee voted to recommend the following amended resolution:

Amended Resolution No. 49-77

WHEREAS, A hospital's policy requiring a physician to answer questions relating to malpractice claims or law suits, and also to submit confidential information concerning his practice of medicine in an application for hospital privileges, may have the effect to harm the physician's reputation in the community; and
WHEREAS, A physician who is a member in good standing of a constituent county medical socicty in the State of Ohio, and has been certified currently by the Ohio State Medical Board to practice medicine in accordance with the statutory regulations should be eligible for hospital staff privileges without being required to answer personal questions which may be incriminating; THEREFORE, BE IT
RESOLVED, That the Ohio State Medical Association Council seek the advice of its legal counsel as to the propriety of requiring a physician to submit information pertaining to malpractice claims or law suits in an application for hospital privileges; and BE IT FURTHER
RESOLVED, That the information be disseminated to the members of the Ohio State Medical Association as soon as possible.

Mr. President, I move the adoption of Amended Resolution No. 49-77.

By official action, the House **voted to adopt Amended Resolution No. 49-77.**

RESOLUTION NO. 53-77
Consultation with Bar Association Regarding Professional Liability Legislation

Resolution No. 53-77 was based on incorrect information. Prior to the passage of H.B. 682, the Ohio State Medical Association sought the advice of the Ohio State Bar Association. Although it is often advisable to work closely with the Ohio State Bar Association, the Committee concluded that it is not always advantageous to do so. Therefore, I move that Resolution No. 53-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 53-77.**

(continued on page 484)



LEFT TO RIGHT: Alford C. Diller, M.D., and Edwin L. Helfman, M.D.

House of Delegates' Proceedings

RESOLUTION NO. 54-77
Professional Liability Surcharge to Corporation

This resolution was based on current law in the state of Pennsylvania which does not apply in Ohio. In Ohio, professional corporations are liable for the acts or omissions of their members and employees. Therefore, I move that this resolution **not** be adopted.

By official action, the House **voted to reject Resolution No. 54-77.**

RESOLUTION NO. 56-77
County Society—PICO Relationships

The next resolution to be discussed by the Committee was Resolution No. 56-77 which dealt with the role of county medical societies in the operation of the Physicians Insurance Company of Ohio. The Committee would like to offer the following amended resolution:

Amended Resolution No. 56-77

WHEREAS, The OSMA House of Delegates and Council created the Physicians Insurance Company of Ohio; and
WHEREAS, The Ohio State Medical Association is now advertising PICO under the OSMA name and emblem encouraging contact with the OSMA office; and
WHEREAS, The role of the county medical societies has not been identified to date; and
WHEREAS, Many county medical societies desire to assist their members in working with the Physicians Insurance Company of Ohio; THEREFORE, BE IT
RESOLVED, That the Council of the Ohio State Medical Association ask the management of the Physicians Insurance Company of Ohio to invite representatives of the county medical societies to work more closely with them.

Mr. President, I move the adoption of Amended Resolution No. 56-77.

By official action, the House **voted to adopt Amended Resolution No. 56-77.**

RESOLUTION NO. 57-77
PICO

The Physicians Insurance Company of Ohio was formed primarily to provide professional liability insurance to the members of the Ohio State Medical Association. One of the most important guaranties for ensuring that PICO shall remain true to its initial purpose and responsive to the needs of OSMA members is the fact that 100 shares having 10,000 votes are owned by the Council of the Ohio State Medical Association. Therefore, I move that Resolution No. 57-77 **not** be adopted.

By official action, the House **voted to reject Resolution No. 57-77.**

The report of Resolutions Committee No. 2, as a whole, as amended was approved by the House.

Report of Resolutions Committee No. 3

Dr. M. Brodie James, Lucas County, reported for Resolutions Committee No. 3, of which he was Chairman. The report is as follows:

RESOLUTION NO. 58-77
OPTOMETRY

The first resolution considered is Resolution No. 58-77, regarding optometry. The resolution has been amended by the Committee as follows:

Amended Resolution No. 58-77

WHEREAS, Vision is one of the most important senses possessed by man; and
WHEREAS, The diagnosis and treatment of eye diseases are extremely complex and serious matters requiring the highest skill and training; THEREFORE, BE IT
RESOLVED, That the OSMA oppose as detrimental to the public interest any legislation that would authorize optometrists to use drugs or to engage in the diagnosis or treatment of diseases or injury of the eye.

Mr. President, I move the adoption of Amended Resolution No. 58-77.

By official action, the House **voted to adopt Amended Resolution No. 58-77.**

RESOLUTION NO. 59-77
Laetrile

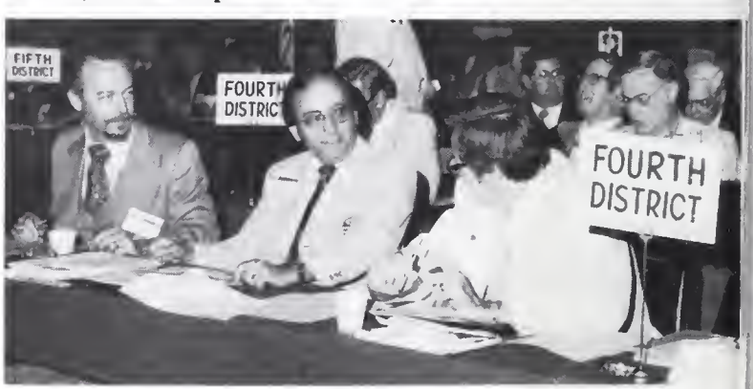
Mr. President, the Committee was in agreement with Resolution No. 59-77 but felt it could be condensed. The committee submits the following substitute resolution:

Substitute Resolution No. 59-77

WHEREAS, Amygdalin (Laetrile) has never been shown scientifically to have any anti-tumor effect; THEREFORE, BE IT
RESOLVED, That the OSMA continue to inform the public and the legislators that the safety and efficacy of amygdalin (Laetrile) for the treatment of or symptomatic relief of malignancy is unproven and that its use in such cases may be harmful by delaying conventionally recognized treatment; *AND, BE IT FURTHER*
RESOLVED, IN THE EVENT THAT THE OHIO STATE LEGISLATURE APPROVES USE OF THE DRUG LAETRILE, THEN IT IS RECOMMENDED THAT THE DRUG LAETRILE BE MADE AVAILABLE TO THE PUBLIC DIRECTLY WITHOUT PHYSICIAN'S PRESCRIPTION IF IT IS DEEMED AS SAFE AS THE USUAL NON-PRESCRIPTION DRUGS.

Mr. President, I move the adoption of this Substitute Resolution No. 59-77.

By official action, the House **voted to amend Substitute Resolution No. 59-77 as indicated by the strike-out deletions and by the additions set forth in capital letters, then adopted it.**



LEFT TO RIGHT: M. Brodie James, M.D.; B. Leslie Huffman, Jr., M.D.; and John A. Devany, M.D.



TESTIFYING: Perry R. Ayres, M.D.

RESOLUTIONS NO. 60-77 and 61-77
Utilization of State Association Leadership by AMA and Utilization of County Society Leadership by OSMA

Mr. President, the next two resolutions deal with the Utilization of State Association Leadership by AMA and the Utilization of County Society Leadership by OSMA. It is felt that a major overhaul of the operations of organized medicine is being requested to correct a problem in communications which may, in fact, be localized in nature. The Committee wished to apprise Council of the continuing dissatisfaction of certain members regarding adequate transmittal of information from higher levels down to local and individual levels. It believes, however, that adequate mechanisms exist within the current structure to correct deficiencies, if these mechanisms are, in fact, used to the fullest intended extent.

The Committee recommends that Resolutions No. 60-77 and 61-77 **not** be adopted and I so move.

By official action, the House voted to reject Resolutions No. 60-77 and 61-77.

RESOLUTION NO. 62-77
To Oppose Repeal of the Drug Anti-Substitution Act

The Committee studied Resolution 62-77 thoroughly and made a slight change in the "RESOLVED." It should read:

Amended Resolution No. 62-77

WHEREAS, A bill to repeal the present Drug Anti-Substitution Act has been introduced into the present session of the Ohio Legislature; and

WHEREAS, Substitution of drugs without the physician's knowledge and consent may result in less than optimum patient care; NOW THEREFORE, BE IT

RESOLVED, That the OSMA adopt an official policy of continuing the practice of having only the physician prescribe—and that prescription may not be altered. Through the appropriate Legislative Committees of the OSMA, efforts should be made to defeat the pending bill to repeal the Drug Anti-Substitution Act/; *AND, BE IT FURTHER RESOLVED, THAT OSMA SUPPORT THIS LEGISLATION PROVIDING THAT IT CONTAINS LANGUAGE WHICH EFFECTIVELY PROTECTS THE PUBLIC FROM THE SUBSTITUTION OF A MEDICINE WHICH DOES NOT MEET THE DEFINITION OF EQUIVALENCY AS DEFINED IN THE PROPOSED LAW.*

Mr. President, I move the adoption of Amended Resolution No. 62-77.

By official action, the House voted to amend Amended Resolution No. 62-77 as indicated by the strike-out deletion and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 64-77
Revision of Drug Advertising Practices

Mr. President, this resolution dealt with the Revision of Advertising Practices. Although the Committee recognized that in many areas of advertising it might be more beneficial to the pharmaceutical companies and the profession if monics expended were directed in some fashion different from the one utilized, it was not felt that a problem was defined adequately within the body of the resolution nor an effective solution proposed.

The Committee recommends that Resolution No. 64-77 **not** be adopted and I so move.

By official action, the House voted to reject Resolution No. 64-77.

RESOLUTION NO. 65-77
Repeal of Amended House Bill 1000 Mandated Uterine Cytologic Examinations

The Committee exercised its prerogative of submitting a Substitute Resolution No. 65-77 to read as follows:

Substitute Resolution No. 65-77

WHEREAS, AM H.B. 1000 requires that hospitals offer uterine cytologic examinations (Paps) to female patients over 18 years of age; and

WHEREAS, This legislation has created exceptional administrative confusion in hospitals, leading to further increased costs, and often proving essentially unworkable; and

WHEREAS, This legislation has introduced unexpected medico-legal problems related to clarification of the agent responsible for these examinations, their scheduling, performance and follow up; and

WHEREAS, Third party payers have now refused in many instances to reimburse hospitals for costs incurred therein; THEREFORE BE IT

~~RESOLVED, That the OSMA work for appropriate modification of said legislation to resolve its inherent problems.~~

RESOLVED, THAT THE OSMA WORK FOR REPEAL OF AMENDED HOUSE BILL 1000 BECAUSE OF MEDICAL-LEGAL, ADMINISTRATIVE, AND THIRD PARTY COVERAGE PROBLEMS, BUT THAT OSMA STRONGLY URGES THE CONTINUATION OF UTERINE CYTOLOGIC EXAMINATIONS FOR WOMEN OVER THE AGE OF 18 YEARS.

Mr. President, I move adoption of Substitute Resolution No. 65-77.

By official action, the House voted to amend Substitute Resolution No. 65-77 as indicated by the strike-out deletions and by the additions set forth in capital letters, then adopted it.

RESOLUTION NO. 66-77
Reaffirmation of Resolution No. 45-66

The Committee found Resolution No. 66-77 proper and acceptable as submitted and voted unanimously that it be adopted, and Mr. President I so move.

The resolution reads as follows:

WHEREAS, There have recently been biased nationwide telecasts, which cast doubt upon the relationship of a physician and/or surgeon to his patient; and

(continued on page 486)

WHEREAS, In 1966, the House of Delegates of the Ohio State Medical Association in Resolution 45, and the House of Delegates of the American Medical Association in Resolution 59, approved the concept that a physician and/or surgeon who receives reimbursement for services which he did not personally provide to the patient, would be acting both unethically and dishonestly; and

WHEREAS, Those statements were directed in 1966 only to subscribers to part B of Medicare by payment of premium; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association hereby reaffirms the principles of Resolution 45, 1966, which declared it unethical and dishonest for a physician to make a charge for services rendered by an intern or a resident without personal supervision of the physician as well as the establishment of a demonstrated patient-physician relationship in the case of Medicare beneficiaries; and BE IT FURTHER

RESOLVED, That this concept be extended to all patients who come under a physician's and/or surgeon's care, irrespective of payment mechanism, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association instruct its Delegation to the American Medical Association to present this Resolution at the Annual Meeting of June 19-23, 1977, seeking its adoption; and BE IT FURTHER

RESOLVED, That a copy of this Resolution be forwarded to all State Medical Associations and all Specialty Societies.

By official action, the House **voted to adopt Resolution 66-77.**

RESOLUTIONS NO. 67-77 and 72-77
Protecting the Consumer Against Inadequately Trained Physicians and Quality Through Self-Determination

The Committee combined Resolution No. 67-77 (Protecting the Consumer Against Inadequately Trained Physicians) and Resolution No. 72-77 (Quality Through Self-Determination) and submits a Substitute Resolution 67-77 to read as follows:

Substitute Resolution No. 67-77

WHEREAS, The U.S. Congress has passed legislation that could influence criteria of admission to medical school, and

WHEREAS, Criteria for admission can also be effected by regulations of the Secretary of Health Education and Welfare rather than depend on traditional criteria or as established by properly appointed admission committees of the medical school; which criteria include adequate premedical education and the medical school aptitude test, and

WHEREAS, Officials of the Wright State University School of Medicine have stated publicly that the college will forfeit federal tax dollars rather than have medical school admission policy dictated by political criteria, and



LEFT TO RIGHT: OSMA Staff member Robert D. Clinger and James C. Good, M.D.

WHEREAS, Officials of the same institution and other medical schools in Ohio continue to encourage admission to medical school from all segments of society while maintaining the highest standard of intellectual ability and character now; THEREFORE BE IT

RESOLVED, That the House of Delegates commend Dean Beljan and Wright State University School of Medicine for resolute adherence to a policy of self-determination and an insistence that quality of applicants will be put ahead of financial considerations or politics in the selection of applicants to medical school, and, FURTHER BE IT

RESOLVED, That the House of Delegates instruct its delegates to the AMA to work for the policy that all educational facilities for medical students select candidates on the basis of the highest ethical and intellectual ideals of medicine rather than yield to ephemeral governmental standards for admission to medical school.

Mr. President, I move adoption of Substitute Resolution No. 66-77.

By official action, the House **voted to adopt Substitute Resolution No. 67-77.**

RESOLUTIONS NO. 68-77 and 74-77
Legal Defense Fund and Information and Legal Issues Which Concern Physicians in Their Practice of Medicine

It is believed that these resolutions do not deal in appropriate fashion with problems confronting the profession at this time. The Committee recognizes and sympathizes with the expressions from the membership of needs which exist within the general framework of "legal matters." There is an obvious lack of knowledge of available legal resources within OSMA from which the membership individually or collectively may draw. There is an equally obvious need for guidance at all levels regarding sources available with reference to questions of law, which questions would be informational in nature.

It is, therefore, the desire of the Committee to direct Council's attention to overt and unanswered needs on the part of the membership relative to a common source for reference and direction at the OSMA level which is capable, willing, and available for answering questions of an informational nature on matters of law and which will provide guidance for members to the appropriate agent or office suited to dealing with the questions of law which may be raised. A definition of the duties and responsibilities of OSMA Legal Counsel should also be forthcoming to help reduce the inappropriate expectations placed upon that group.

The Committee recommends that Resolutions No. 68-77 and 74-77 **not** be adopted, and I so move.

By official action, the House **voted against the Committee's recommendation, then accepted a Substitute Resolution No. 74-77, submitted by Stanley J. Lucas, Delegate from Hamilton County.** Substitute Resolution No. 74-77 reads as follows:

Substitute Resolution No. 74-77
Information on Legal Issues Which Concern Physicians in Their Practice of Medicine

WHEREAS, There is a need of the membership in the general framework of "legal matters"; and

WHEREAS, There is a lack of knowledge of available legal resources within the OSMA from which the county medical societies may draw; and

WHEREAS, There is an equally obvious need for guidance regarding sources available with reference to questions of law, which questions would be informational in nature; THEREFORE, BE IT

RESOLVED, That the Council of the Ohio State Medical Association recognize the needs and develop at the OSMA level a system which would make available the appropriate answering of questions of an informational nature on matters of law and which will provide guidance for county medical societies to the appropriate agent or office suited to dealing with the questions of law which may be raised; and BE IT FURTHER

RESOLVED, That the Council of the OSMA define the duties and responsibilities of OSMA legal counsel to help reduce the inappropriate expectations placed upon that group.

By official action, the House **voted to adopt Substitute Resolution No. 74-77.**



LEFT TO RIGHT: P. John Robechek, M.D., and John J. Gaughan, M.D., visit one of the exhibits and test a product.

RESOLUTION NO. 69-77
Annul Compulsory Continuing Medical Education

Mr. President, although the use of the term *compulsory* was generally construed as repugnant, it was conceded that the law and regulations are serving useful purposes and their existence should not be assailed at this time.

The Committee recommends that Resolution No. 69-77 **not** be adopted, and I so move.

By official action, the House **voted to reject Resolution No. 69-77.**

RESOLUTION NO. 71-77
Not an Ethical Issue

The Committee found this resolution to be vague. There was no way of accurately determining its intent.

The Committee recommends that Resolution No. 71-77 **not** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 71-77.**

RESOLUTION NO. 73-77
Elimination of Discriminatory Hiring Practices Relating to the Handicapped

The Committee felt that Resolution No. 73-77 deals with material which has already been enacted into legislation and is otherwise redundant to stated OSMA policy.

The committee recommends that Resolution No. 73-77 **not** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 73-77.**

RESOLUTION NO. 75-77
Recommended Alterations of Hospital Discharge Summaries

It was the consensus of the Committee that this resolution should be rejected because the information required in the discharge summary by the JCAH is information which should appear in the patient's medical record.

Mr. President, the Committee recommends Resolution No. 75-77 **not** be adopted, and I so move.

By official action, the House **voted against the Committee's recommendation, then accepted the following Substitute Resolution No. 75-77, submitted by the Hamilton County Delegation:**

Substitute Resolution No. 75-77

WHEREAS, We agree that hospital discharge summaries should be concise documents of a patient's hospital course and follow up; and

WHEREAS, The JCAH requires that all discharge summaries now document in meticulous detail that instructions have been given to patients with respect to specific activity, diet, drugs, and follow up visits; and that these instructions are understood by the patient; and

WHEREAS, Documentation of such instructions in detail does not improve patient care and is almost impossible to attain; and

WHEREAS, The attempt to write such all-inclusive documentation of necessity leads to potential liability for exclusion; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association request the American Medical Association to urge the JCAH to have those specifications of the detailed post-hospital instructions deleted from the regulations of the Joint Commission.

By official action, the House **voted to adopt Substitute Resolution No. 75-77.**

RESOLUTION NO. 76-77
Physician Assistant Legislation

The Committee felt that although there are points of merit within this resolution, the testimony received during hearings made it evident that the resolution as a whole was not timely and that it dealt with some subjects, such as specialty accreditation, that require further extensive study and work before they should be considered.

Mr. President, the Committee recommends Resolution No. 76-77 **not** be adopted and I so move.

By official action, the House **voted to reject Resolution No. 76-77.**

RESOLUTION NO. 77-77
Contraceptive Services for Minors

Both the testimony as presented during the hearings and the considerable discussion by the Committee disclosed a diversity of opinion, and by a majority vote the Committee recommends that the resolution **not** be adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 77-77.**

RESOLUTION NO. 78-77
Balanced News Presentations on Socioeconomics of Medicine

The Committee exercised its prerogative of submitting a Substitute Resolution No. 78-77 to read as follows:

(continued on page 488)

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Substitute Resolution No. 78-77

WHEREAS, There is no higher quality medical care in the world than that provided to the American public, and

WHEREAS, Non-physician sources have frequently provided the American people with inaccurate, biased or incomplete information regarding the status of health care and its provision in this country, and

WHEREAS, The American people can make sound decisions in these matters only when in possession of full and true facts, and

WHEREAS, Bureaucratic involvement in the socioeconomics of medical care can be detrimental to successful methods of providing health care; THEREFORE, BE IT

RESOLVED, That the media be requested to contact their local medical societies or the Ohio State Medical Association for information from a qualified spokesman to present the physician's point of view; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association, through its component medical societies, provide a group of qualified spokesmen to respond in a constructive, reflective manner to the news media's requests; and that a copy of this resolution be submitted along with a covering letter explaining its contents to all County Medical Society Presidents and all appropriate news media.

Mr. President, I move adoption of Substitute Resolution No. 78-77

By official action, the House **voted to adopt Substitute Resolution No. 78-77.**



LEFT TO RIGHT: Robert E. Howard, M.D., and William Dorner, Jr., M.D.

RESOLUTION NO. 79-77
Insurance Coverage for Alcoholism Treatment

The Committee recommends the following Substitute Resolution:

Substitute Resolution No. 79-77

WHEREAS, Alcoholism is currently recognized as an illness or disease by the American College of Physicians, the World Health Organization, the American Medical Association, the American Psychiatric Association and the American Hospital Association; and

WHEREAS, Successful rehabilitation of the alcoholic often requires hospital treatment, not only for medical complications, but also for the alcoholism itself; and

WHEREAS, Many third-party payers do not consider alcoholism to be an illness or disease; and

WHEREAS, These third-party payers limit coverage solely to treatment of medical complications of alcoholism; THEREFORE, BE IT



LEFT TO RIGHT: Thomas P. Price, Jr., M.D.; Lethia W. Starr, M.D.; and A. Burton Payne, M.D.

RESOLVED, That the OSMA *CONTINUE TO* recognize alcoholism as an illness or disease; and BE IT FURTHER

RESOLVED, That the OSMA *CONTINUE TO* actively support treatment of alcoholism, and BE IT FURTHER

RESOLVED, That the OSMA request that the health insurers investigate the possibility of making available to patients a policy which ~~could~~ *WOULD* cover treatment of alcoholism in whatever setting is most appropriate*/ AND COST EFFECTIVE.*

Mr. President, I move adoption of Substitute Resolution No. 79-77.

By official action, the House **voted to amend Substitute Resolution No. 79-77 as indicated by the strike out deletions and by the additions set forth in capital letters, then adopted it.**

RESOLUTION NO. 80-77
Physician Effectiveness Programs

The Committee felt that the problem could be detected and treatment instituted earlier if done on a local level (county society).

The Committee found Resolution No. 80-77 proper and acceptable as submitted and voted that it be adopted, and Mr. President I so move.

The resolution reads as follows:

WHEREAS, The Ohio State Medical Association offers a "Physician Effectiveness Program" for those whose ability to practice medicine is impaired by problems associated with excessive use of alcohol or drugs, mental illness, or senility; and

WHEREAS, The program is conducted by a small group of highly dedicated physicians who serve on the OSMA Committee on Mental Health; and

WHEREAS, The American Medical Association, during national conferences on the disabled physician in 1975 and 1977 has urged in addition to programs offered by state medical associations, formation of programs at the local level to be offered by county medical societies and medical staffs of hospitals; and

WHEREAS, Programs offered at the local level could often meet a physician's problem at an earlier stage—thus improving the chances for full recovery; THEREFORE, BE IT

RESOLVED, That each county medical society in Ohio be urged to form a special Physician Effectiveness Committee to work on a local basis—and, when necessary, to work in cooperation with the state-wide program; and BE IT FURTHER

RESOLVED, That the OSMA Physician Effectiveness Program offer guidance and the expertise of its members to help local programs get under way; and BE IT FURTHER

RESOLVED, That OSMA work in cooperation with the Ohio Academy of Family Physicians, Ohio Psychiatric Association, other interested specialty societies, and Ohio members of the International Doctors in Alcoholics Anonymous to plan and develop continuing education programs for physicians participating at both the local and state level.

By official action, the House **voted to adopt Resolution No. 80-77.**

RESOLUTIONS NO. 81-77 and 82-77
Improved Effectiveness of the Ohio State Medical Board and Ohio State Medical Board

The Committee decided to consider Resolution No. 81-77 (Improved Effectiveness of the Ohio State Medical Board) and Resolution No. 82-77 (Ohio State Medical Board) together and Substitute Resolution 82-77 will cover both resolutions.

The Committee offers Substitute Resolution No. 82-77 as follows:

Substitute Resolution No. 82-77

WHEREAS, Efficient operation of the Ohio State Medical Board is essential to the high quality of health care in Ohio; and

WHEREAS, The Board's duties encompass licensure, discipline, continuing medical education, and statutory obligations to regulate the practice of medicine and several allied health professions; and

WHEREAS, The Board's performance is under constant scrutiny by the Ohio General Assembly which determines its biennial budget as well as its statutory obligations; and

WHEREAS, The Ohio General Assembly has proposed a 30 per cent reduction in the Board's budget for the next biennium; and

WHEREAS, The proliferation of legislation to establish separate boards for several allied or limited health professions, plus legislation to abolish the Ohio State Medical Board and establish a single "health professions board," presents a potential threat to delivery of high quality health care; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association place immediate, high priority on—and seek every means at its disposal to:



LEFT TO RIGHT: Thomas W. Morgan, M.D.; Robert R. Clark, M.D.; and Oscar W. Clarke, M.D.



LEFT TO RIGHT: OSMA Staff members Carolyn I. Gary and Katherine E. Wisse with C. Edward Pichette, M.D.

1. Seek restoration of the Board's proposed 30 per cent budget reduction for the next biennium.
2. Firmly oppose the placement of physicians' and allied medical practitioners' licensure fees into the general fund. These fees should be earmarked by the state for the sole use of the Board to meet its increasing responsibilities and obligations.
3. Vigorously oppose legislation to establish a single "health professions board."
4. Encourage, through close liaison with the Board, efficient operating procedures to carry out its mandated responsibilities.
5. Consider amendments to the Medical Practice Act which would improve the function of the Board by clearly defining major responsibilities.
6. Effect closer liaison with the Governor and the General Assembly in the process of nominating qualified physicians for positions on the Board.
7. Effect a continuous flow of information in OSMA publications in order to keep physicians current on Board activities, procedures, and major problems which call for remedial action.

Mr. President, I move adoption of Substitute Resolution No. 82-77.

By official action, the House **voted to adopt Substitute Resolution No. 82-77.**

RESOLUTION NO. 84-77
Fee Contracts With Patients

The Committee felt that this resolution dealt with a local matter and did not justify its claims for time, services, and monies from OSMA. Methods of dealing with inadequate fee information by physicians and inaccurate statements by third party insurers were discussed before the Committee; and it was, therefore, determined that the resolution did not address current OSMA concerns.

Mr. President, the Committee recommends that Resolution No. 84-77 **not** be adopted, and I so move.

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By official action, the House **voted to reject Resolution No. 84-77.**

RESOLUTION NO. 87-77
JCAH Standards

The hearing on this resolution reveals that there were problems of communication between the members of the OSMA and the JCAH committee regarding interpretation of their latest directive and recommends that this resolution be referred to the Council for further study and possible action and that the Council report its findings to the House of Delegates during the 1978 Annual Meeting.

Mr. President, the Committee recommends that Resolution No. 87-77 be referred to the Council.

By official action, the House **approved the Committee's recommendation that Resolution No. 87-77 be referred to the Council of the Ohio State Medical Association.**

The report of Resolutions Committee No. 3, as a whole, as amended, was approved by the House.

INAUGURAL CEREMONY

Mrs. Bates was introduced and escorted to the podium by Dr. C. Douglass Ford. Dr. Lieber then presented President's medallion pins to Dr. and Mrs. Bates and the certificate of honor to Dr. Bates.

Mrs. Wells, with sons Bruce and Steven, was escorted to the podium by Dr. Ford. After they were introduced to the House, Dr. Lieber administered the presidential oath of office to Dr. Wells; and Dr. Bates, retiring President, presented Dr. Wells the official gavel and the President's medallion. Dr. Wells presented to Dr. Bates the Past-President's button.



LEFT TO RIGHT: William M. Wells, M.D.; George N. Bates, M.D.; James E. Pohlman, Esq.; Mrs. Bates; and Robert G. Thomas, M.D.

Dr. Wells made brief comments regarding the conduct of the House of Delegates, in view of the volume of work accomplished, and outlined some future projects for 1977-1978.

There being no further business, the House of Delegates adjourned sine die.

ATTEST: Hart F. Page
Executive Director



BELOW (left to right): Newly installed OSMA officers for the year 1977-1978— President-Elect John J. Gaughan, M.D., and Mrs. Gaughan; President William M. Wells, M.D., and Mrs. Wells; and Past President George N. Bates, M.D., and Mrs. Bates.

OSMA OFFICERS, COUNCILORS, AND AMA DELEGATES

Editor's Note: The following physicians are currently holding office. L.A.J.

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Linda A. Jacobson, *Executive Editor and Executive Business Manager*

Mary Lou Brady, *Editorial Ass't.*

Presidential Address

George N. Bates, M.D., President, Ohio State Medical Association

Delivered to the OSMA House of Delegates on May 15, 1977

When I last stood before this House, it was to conclude an historic special session in which the House overwhelmingly approved the formation of a professional liability insurance company for members of this Association.

At that meeting, I emphasized that Ohio medicine must ". . . proceed immediately to do those things that must be done."

Physicians Insurance Company of Ohio

It is a great pleasure then . . . and with a great sense of accomplishment . . . that I am able to report to you this evening that PICO—The Physicians Insurance Company of Ohio—is an active, soundly-financed, well-managed and, most importantly, physician-directed professional liability insurance company which is already meeting the insurance needs of nearly 2,000 members of this Association.

You have learned directly about PICO and about the professional liability situation in Ohio from two current reports: one report from PICO and the second from OSMA's Professional Liability Insurance Task Force.

But, I will take this opportunity to report that effective May 2, 1977, PICO, by authority of its Board, began offering $200,000/$600,000 coverage to its insureds. PICO management is presently negotiating with three reinsurance entities, and we hope that within a few weeks we can offer a $1 million excess policy to PICO insureds.

Many other boards would have acted more precipitously, but your Board is concerned with the stability and long-range success of the organization and will not act in any way to jeopardize that future financial stability.



LEFT TO RIGHT: George N. Bates, M.D., and OMPAC Chairman H. William Porterfield, M.D., accept an award recognizing increased OMPAC membership from Rex E. Kenyon, M.D., Chairman of the American Medical Political Action Committee.

I urge you to study carefully and analytically the report from PICO as well as the report of the Task Force. These will help to guide you in the many resolutions you are to consider that involve professional liability problems.

These reports should give you—as they have given me — a sense of pride in being a member of the Ohio State Medical Association.

I am also happy to announce that the Board of Directors of PICO has approved a proposal to begin the issuance of other lines of property and casualty insurance — automobile, homeowner and multiperil policies — and that these policies will be available July 1, 1977 to OSMA members. The decision by the Board was made not only in response to a demonstrated desire by the membership for such additional lines of insurance but also as a means for strengthening further the financial base of PICO.

I am fully aware, of course, that there has been criticism of some of PICO's administrative and underwriting policies. I do not condemn these critics. Any organization of nearly 11,000 members, especially physician members, is bound to have differences of opinions among its members. If it didn't, it would be a dead organization.

American Medical Association

All Ohio members of the American Medical Association are in agreement, however, in looking forward with considerable anticipation to the American Medical Association's Annual Convention in San Francisco next month. It is at that meeting that one of OSMA's Distinguished Service Award recipients — Dr. John Budd of Cleveland—will be installed as President of the AMA, and another, Dr. Robert M. Zollinger of Columbus, will receive the Sheen Award, medicine's highest.

At that same meeting, the OSMA delegation will nominate for the office of Vice Speaker of the House of

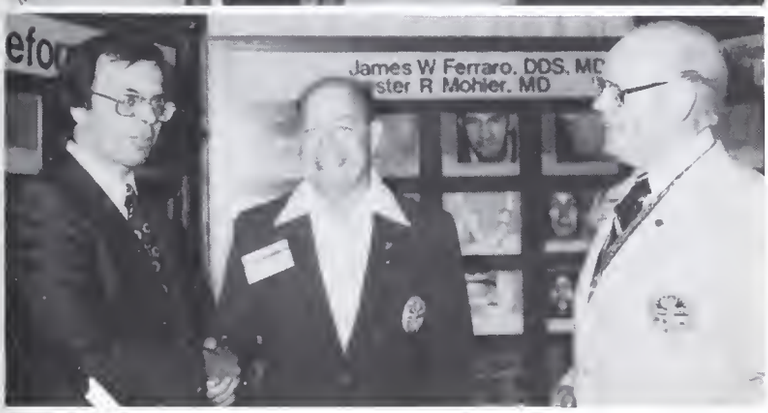
(continued on page 494)

On page 493, George N. Bates, M.D., and Thomas W. Morgan, M.D., are shown presenting the scientific awards. Exhibits honored are COLUMN ONE (top to bottom): *Clinical Investigation:* (1) Gold Award— "Management of Penetrating Eye Injuries" Doctors C. R. Kollarits and T. Isseks (pictured). (2) Silver Award— "Noninvasive Diagnosis of Thrombophlebitis (Phleborheography)" and "Noninvasive Diagnosis of Carotid Artery Stenosis" Doctors J. J. Cranley, K. Mahalingam (pictured with Mrs. Mahalingam), and E. B. Ferris. (3) Honorable Mention— "Electrocochleography-Its Place in the Diagnosis of Hearing Loss" C. P. Hobeika, M.D. (4) Honorable Mention— "Surgical Treatment of Traumatic and Congenital Jaw Deformities" Doctors J. W. Ferraro (pictured), L. Mohler, H. Wm. Porterfield, and G. Drabyn. Not Shown: Bronze Award— "Diagnosis &










Treatment of Palmar Hyperhidrosis" Doctors G. M. Sava and D. F. Dohn.

COLUMN TWO (top to bottom): *Original Research:* (1) Gold Award— "Treatment of Leg Ulcers with 20% Benzoyl Peroxide" G. Colman, M.D. (pictured). *Teaching:* (2) Gold Award— "Breast Cancer Management, 1977" and "Colo-rectal Cancer Management, 1977" J. P. Minton, M.D., Ph.D. (3) Silver Award— " 'True' Thoracic Outlet Syndrome" Doctors R. W. Hardy, Jr., and A. Wilbourn (pictured). (4) Bronze Award— "Patient Education for Venous Disorders of the Lower Extremities; Care of Atherosclerotic and Diabetic Feet" Doctors S. M. Dosick and Wm. S. Blakemore. (5) Honorable Mention— "Nosocomial Infections" I. M. Baird, M.D.

Presidential Address *(continued)*

Delegates of the AMA, Dr. Jack Lewis of Dayton, our Second District Councilor and an OSMA Delegate to the AMA. We are confident that the AMA House will look favorably upon that nomination.

It is not by accident that the OSMA and its Delegation take an active and positive interest in AMA. We support AMA at every opportunity. We may, on a few occasions, differ with an AMA policy or AMA approach, but if we do, and when we do, we voice that difference in a positive manner, avoiding the negativism too frequently practiced toward AMA — some of which is being practiced right here in Ohio.



LEFT TO RIGHT: Jerry L. Hammon, M.D.; OSMA Staff member Gail E. Dodson; John E. Albers, M.D.; and George N. Bates, M.D., attend a meeting of the OSMA Committee on Scientific Work.

There are some physician groups that seem to devote their entire energies toward attacking the one national voice for all of medicine. They spend most of their time criticizing AMA and little time opposing the inroads of government domination being made by Congress and by the federal bureaucracies.

Every time they unleash a blast at our national orgazation, OSMA suffers as does every other state association and, indeed every county medical society. For example, the Council of OSMA is deeply concerned about our dwindling AMA membership. We were, and still are, on the verge of losing a delegate and alternate delegate to the AMA. Remember, medicine's problems are in Washington—not Chicago.



Mrs. George N. Bates is escorted to the podium by C. Douglass Ford, M.D., for ceremonies honoring the Bates.

If we lose that delegate, that loss diminishes our effectiveness in the AMA House of Delegates. It is tragic that those who so often criticize AMA leadership fail to recognize or to admit that the leadership is carrying out directives of the House of Delegates. If those detractors of our one national organization that speaks for all of medicine don't like what the House of Delegates decides, they ought to try to do something about it.

They can first join the AMA. Secondly, they can work within their state associations to elect some of their numbers to the AMA House of Delegates. If their spokesmen are not elected delegates, that is hardly the responsibility of the AMA.

These poorly or uninformed detractors have, as an example, bitterly attacked the AMA for sponsoring what they incorrectly call federal health care legislation. Let me point out a couple of facts here and now:

First, the legislation being sponsored by AMA is not a federal health care bill. It is a bill to foster and to strengthen payment for health care services through the private sector. Further, the AMA bill would remove the pressure for expanding existing programs by helping needy citizens to pay their private health insurance premiums.

Secondly, these same detractors repeatedly attack the AMA leadership for this legislation. They fail to point out that this legislation has been approved repeatedly by the AMA House of Delegates. They forget the fact that 50 state association houses of delegates—such as this House of Delegates—who represent medicine's real grass roots—the county medical society—elect the delegates to the AMA House. Those are the physicians who chart the course for the AMA and who elect the AMA leadership.

Personally, I would rather be a member of the team and playing to win than be a non-participating, Monday morning quarterback.

I would remind you that OSMA has been an ardent supporter of a stronger AMA. Time and again, we have made that position known with no hesitation.

Therefore, the OSMA may wish seriously to consider modification in the structure of the federation in order to create a stronger American Medical Association. This will enable it to become more responsive to the needs of the profession, will increase its membership, and will provide a sound fiscal basis which will allow it to accomplish the missions generated by its House of Delegates.

We have learned that the 1976 AMA membership totaled 204,000 (persons) in the first year following a major dues increase, about 173,000 (members) in the dues-paying category. While this appears laudable, it is nontheless disturbing, for there are 409,000 physicians in the U.S.A., 150,000 of whom belong to no medical society at all. Fifty-six thousand county and state members have not lent their support to medicine by joining the AMA.

How best and most effectively can the AMA be organized and structured? Now obviously, AMA has



George N. Bates, M.D., presents Richard L. Meiling, M.D., Consulting Medical Editor of *The Journal,* a plaque in recognition of 20 years' service on the AMA Delegation.

given much consideration to this question, but to date, AMA's response has not entirely pleased many of its component societies including our own. It is, therefore, time for us to reason together. Reasonable men should reach reasonable conclusions. AMA's concerns and plans should be shared with organizations such as OSMA, so that we can react and make known our response to the problems currently besetting our parent.

Our goal, obviously, should be to strengthen our representative voice.

I encourage the dialogue. Let's get on with it.



Political Analyst Richard M. Scammon poses with George N. Bates, M.D., following the Ohio Medical Political Action Committee luncheon at which Mr. Scammon spoke.

Federal Legislation Affecting Medicine

Nowhere should this collective voice be raised more loudly than in Washington. It appears clear that health care costs are receiving much attention there and elsewhere. The Carter Administration has shown some reluctance to introduce a comprehensive plan for just this reason, preferring to employ an incremental approach. Reports from Washington demonstrate that the first suggested change has been directed toward hospital charges and the second may well be—(although denied)—a comprehensive, compulsory, physician fee schedule—the very technique the FTC has labelled so insidious.

Nonetheless, this appears to be the strategy; and the AMA must present our views in no uncertain manner.

This being the case, the various national health insurance bills now have a somewhat precarious appearance. You can be assured though, they still lurk out there somewhere.

The AMA last March (1977) succeeded in having deleted a most obnoxious section in the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977. This section would have defined any office shared by two or more physicians as a "shared health facility." The deleted language provided that federally financed Professional Standards Review Organization could request from HEW the responsibility to review the records of physicians in a "shared health facility."

I am pleased to report that your OSMA assisted the AMA in achieving the deletion of that definition, using the facilities of our newly organized Department of Federal Legislation, created to assist and supplement the Washington Staff of the American Medical Association.

Currently, the Health Subcommittee of the House Committee on Ways and Means has a Medicare Task Force studying methods of improving the Medicare program.

On behalf of the Ohio State Medical Association, I submitted a statement to the Health Subcommittee containing specific recommendations for improving Medicare.

This statement included a request for support of the American Medical Association's PSRO amendments, in the form of H. R. 4510. I urged that the subcommittee support the establishment of an advisory council consisting of privately practicing physicians to give Medicare and Medicaid advice to the Committee on Ways and Means.

I strongly believe that continuous dialogue between practicing physicians who are personally caring for Medicaid patients and the Ways and Means Committee can be a most effective, most constructive mechanism.

State Legislation Affecting Medicine

On the Ohio General Assembly level, it continues to be a most active year for Ohio Medicine. Again, there are many bills that require our constant and serious attention: professional liability legislation; a separate licensing board for physical therapist; definition of death; anesthesiologist assistants; use of diagnostic drugs by optometrists, and redefining their practice; repealing Ohio's anti-substitution drug law; state drug formulary council to identify interchangeable drugs; venereal disease education in schools; geriatrics training in medical schools; restructure of Ohio's health financing and planning statutes; and on and on.

I sincerely hope that your own county society committees on state legislation are active. I hope that each

(continued on page 496)

Presidential Address *(continued)*

county society meeting agenda includes ample time for a discussion of state legislation. I strongly urge your serious attention to our legislative bulletins. It is equally important that you talk to your State representatives and State senators about bills involving our profession.

While you are in Columbus, I recommend that you pay a courtesy call on your State legislators. They will be pleased to see you.

OSMA House of Delegates' Directives

Your OSMA Council, committees, Delegation to the AMA, and OSMA Staff have worked diligently in carrying out the directives set forth by this House in 1976. I call to your attention the action report prepared especially for this House and listing the action report prepared especially for this House and listing the steps taken in carrying out your directives.

There is work to be accomplished close to home. The history of several recent Houses of Delegates suggests that the resolutions presented for adoption are in some measure provincial and personal, ofttimes negative and querulous, seemingly unconcerned with the future course of medicine or the good of the order. In my opinion, we must address the problems of medicine directly and in concert. We must become positive. We would be well advised to engage in a little strategic planning. Our resolutions must reflect our intentions as well as our concerns.

I would point out that Council, too, has an obligation to anticipate the future, balance short-range objectives and long-range goals, and establish priorities. This should be a continuous process that considers the impact on the future of decisions made today, that organizes the efforts needed to carry out these decisions, and that measures the results of the decisions.

This House of Delegates has its own responsibilities which it must exercise. With that in mind, I would propose, following the advice of the District Caucus, that all resolutions remain the property of and the responsibility of the author until such time as they become the property of the House by referral to the reference committees at the opening session of the Annual Meeting.

Each should bear the name or names of the author or authors and this includes those suggested by the Council of the Ohio State Medical Association.

Further, each should be accompanied by a disclaimer as far as OSMA is concerned and none should be viewed as OSMA position or posture until or unless passed by the House of Delegates.

It would be my feeling further that a mechanism be developed to aid the authors of resolutions in their work of drafting. Guidelines and format should be supplied so that meanings and intentions are clear.

It would be well for this to be the responsibility of the House; and I would propese that a committee of the House be formed, comprised of one delegate from each Councilor District, the chair to be rotated annually by District. The District Councilor, following advice gathered from his individual county visitations or otherwise, could appoint such a committee member.

Health Care Cost

I also have much concern over the issue of health care cost. There are many cost-containment and cost-effectiveness committees wrestling with this concept. One of the best known is the National Commission on Costs of Medical Care of the AMA. I felt that a member of OSMA should be a member of that committee, but we were unable to obtain a seat. We do have members on numerous other committees dealing with costs and are contemplating the establishment of a "Cost Effectiveness Round Table" which will include leaders in industry, labor, and the professions as well as OSMA members.

One efficient method for delaying National Health Insurance might be to slow the escalation of health care cost. In my mind, this probably would be the most effective available mechanism.

In reference to the escalation of health care costs, it becomes obvious that the presence of first-dollar coverage has brought about a lack of cost consciousness. Couple this with an apparent high expectation of health care and the failure of the usual market place factors, and there'll be an upward movement in prices.

Advancing technology must not be overlooked as a factor, for it has increased costs. Sophistication in technology probably is the most significant factor in this regard.

Perhaps in dealing with all of this, we must advocate sharing of costs by patients. Maybe Health Maintenance Organizations and Independent Practice Associations need to be encouraged. Variable cost health insurance may be indicated; and health planning must not be overlooked by us, for it certainly will not be by anyone else.

In the past year, we have seen significant steps taken in implementation of the National Health Resources Development and Planning Act of 1975. Ohio has been divided into health service areas. Those areas have completed or are completing organization of their powerful health systems agencies (HSAs).

Our fears and expectations have been realized. The legislated, overwhelming domination of the HSA's by non-physicians—which we predicted—has come about. Fortunately, some HSA's include articulate and dedicated



LEFT TO RIGHT: John J. Gaughan, M.D., and George N. Bates, M.D., following the inauguration of William M. Wells, M.D., as OSMA President.

physicians who will do their utmost to represent medicine.

The Constitutionality of this law is under challenge in Federal Court. AMA has joined the State of North Carolina, the North Carolina Medical Society, and the State of Nebraska in legal action against the law.

As OSMA did when the legislation was passed, I again urge the county medical societies to give constant attention to the planning activities in their respective health service areas. This requires our eternal vigilance.

The Future of Medicine

I want to express my heartfelt appreciation to the OSMA Officers and Council, the many committee members, the AMA Delegation, and the OSMA Staff for helping to make this a positive and productive year for our Association.

And now we come to that annually asked question: "What is the future of medicine?" Although Maurie Lieber, I understand, had a crystal ball, I am not as fortunate. One thing is certain, there'll always be problems. Representative is H.B. 3816 with its dangerous and frightening enhancement of power in the FTC (Federal Trade Commission) to expand its jurisdiction to any person, partnership, corporation, legal entity, or non-profit entities—to demand information and penalize failure to comply, to limit challenges to its authority, and on and on. The FTC, in the unfortunate event of the passage of H.B. 3816, would become a most potent force—the likes of which we have never even imagined!

Yes, there seems to be even more fear and fright in our future.

I am delighted to report to you that just last Wednesday (May 11, 1977), the House Interstate and Foreign Commerce Committee voted to delete from the bill that section giving the FTC regulatory authority over non-profit organizations. Further, the Committee rejected a motion to have the FTC study and recommend one year from now whether or not non-profit organizations should be so regulated. Additionally, the Committee watered down considerably a section which would have opened the door for an FTC trusteeship of any organization it deemed to be in violation of FTC edicts.

Much of the credit for this important victory for medicine goes to Ohio Congressmen Samuel L. Devine, Charles J. Carney, and Clarence J. Brown. They strongly supported medicine's position as members of the Committee. Also, we owe the AMA Washington Office a great deal for its tremendous efforts in this accomplishment. Finally, I am proud to say that OSMA played a significant role in this victory.

I, quite frankly, am somewhat concerned with our public image—how we are perceived by others. Oh, I am familiar with the polls which suggest that we are held in higher esteem than most, if not all others. That fails to satisfy me for I also read the newspapers, watch television, and listen to radio; and what I read and what I see and what I hear suggests a different conclusion. Too often we have allowed others to speak for us.



George N. Bates, M.D., presents a Medical Journalism Award.

No one knows our field better than we. We can supply accurate information through specific medical spokesmen. Among us, we have articulate members who could and should present our views. In the past, our members have felt somehow that such activity was unethical. Let's lay that attitude to rest. Let's cooperate with the media to the extent that they have clear access to us and our views. Let's not let others speak for us.

I believe there is in this nation a growing awareness that swift enactment of ill-considered national health care legislation could create medical chaos and financial disaster.

I believe Washington is becoming more and more aware that our health care resources—like our energy resources are not unlimited. They are becoming cognizant of our warnings that creating an untethered demand for our services would be catastrophic.

I sense an emerging awareness of the fact that this nation's economic capabilities are not unlimited, as some would have us believe.

I sense a growing distrust of the ever-widening regulatory excesses of the federal agencies, and a growing conviction that those excesses must be terminated.

I believe there is distrust among Congressmen, the news media, and the public, of the too frequent and ill-conceived public pronouncements emanating from Washington. A good example is the recent fiasco of wrongly identifying Medicaid providers paid $100,000 or more in one year.

I am convinced that we in medicine, by continuing to adhere to our beliefs; by continuing to offer positive alternatives to negative proposals; by continuing and expanding our leadership in health care delivery; by becoming more cooperative and less divisive among ourselves; and by continuing to improve and to expand the best health care in the world . . .

By doing these things, we will, to the benefit of all our patients, preserve and continue to provide the quality medical care that every patient expects of his physician.

This, friends, is American medicine at its finest.

As I asked of you on the occasion of my inaugural remarks just one year ago, I again ask of you:

Let us always go forward not with a sense of ending . . . But a sense of beginning.

Report on the 1977 OSMA Auxiliary Convention

Mrs. William Myers, President
Ohio State Medical Association Auxiliary

The 37th Annual Convention of the Ohio State Medical Association Auxiliary was both innovative and exciting. Highlighting the opening of the Convention was a general session entitled "Public Attitudes Toward Health Care and Malpractice Solutions." Sponsored jointly by the Auxiliary and the OSMA, the session covered the influence of changing life styles on the attitudes of the public toward physicians and health care. During the two-hour session, these attitudes were discussed with the hope of stimulating more effective communication between physicians and their patients. A public opinion survey conducted under a grant from the OSMA provided the material for this presentation.

Another program featured Dr. Leslie J. Chamberlin whose topic, "How Television Is Changing Our Children," emphasized the influence of TV as a powerful, pervasive force in a child's development. The Auxiliary agreed to assist Dr. Chamberlin in further research with a financial contribution and with help in monitoring programs and taking surveys.

Year-end reports revealed the excellent work of American Medical Association-Education and Research Foundation (AMA-ERF) Chairwomen Mrs. Kenneth Harshman and Mrs. John Liambeis. With the help of all county auxiliaries, Ohio increased its contributions to AMA-ERF by 68 percent, for a total of $62,846.29. The OSMA Council voted to contribute another $3,000, for a grand total of $65,846.29. The Auxiliary hopes to win an award at the National Convention in San Francisco for this outstanding effort.

The Auxiliary has continued its involvement in community health concerns. Thirty-five counties have reported health service projects this year— some ongoing, some new. Auxilians have presented programs on breast self-examination, cardiopulmonary resuscitation, meals on wheels, child abuse, diversional therapy, television's effect on children, venereal disease, safety on the streets, and phases of family life.



LEFT TO RIGHT: OSMA Auxiliary President Joy Myers and OSMA Auxiliary President-Elect Ingrid May.



Mrs. Myers is escorted to the podium of the OSMA House of Delegates by J. Hutchison Williams, M.D.

It is fascinating to read in county reports of the number and variety of programs in operation all over Ohio. Auxilians have assisted their communities in health education, conducting programs in schools on sex education, nutrition, and safety. Many counties have on-going programs about health careers. In addition, thousands of dollars are given each year in scholarships.

Auxiliary members serve on boards and in public office in order to inform the public of Auxiliary views when medical and health-care issues are discussed. The Auxiliary is represented on the board of Health Careers of Ohio, the Ohio State Planning Committee for Health Education, and the Ohio Nutrition Council.

During the Convention, the following Auxiliary officers were elected for the 1977-1978 term: Mrs. Albert May, president; Mrs. Emil Barrows, president-elect; Mrs. Ernest Fox, 1st vice president; Mrs. Kenneth Harshman, 2nd vice president; Mrs. Armin Melior, 3rd vice president; Mrs. Jerry Hammon, treasurer; Mrs. Angelo Demis and Mrs. W. J. Pignolet, directors-at-large; Mrs. Robert Stegemiller, Mrs. Jose Albernaz, Mrs. Sam Sato, Mrs. James Current, Mrs. James Zimmerman, and Mrs. Joel Kaye, district directors.

Mrs. William Walker, AMA Auxiliary Director, spoke to the Auxiliary Delegates and conducted the installation of new officers. She also announced that Mrs. Louis Loria had been nominated by the National Auxiliary to serve as a director and Mrs. William Myers had been appointed to serve as Northcentral Regional Project Bank Coordinator.

COLUMN ONE (top to bottom): (1) J. Hutchison Williams, M.D., and his son, James H. Williams, Jr., M.D., confer with Frank McEldowney of Ohio Medical Indemnity. (2) Left to right: Maurice L. Lieber, M.D.; William M. Wells, M.D.; and OSMA Parliamentarian James L. Golden. (3) Charles L. Hudson, M.D., Past President of both the AMA and the OSMA, addresses a reference committee.

COLUMN TWO (top to bottom): (1) Chairman of the OSMA Task Force on Professional Liability James L. Henry, M.D., and W. Wayne Talarzyk, Ph.D., and Roger D. Blackwell, Ph.D., researchers who conducted a health care consumer survey for the OSMA. (2) Left to right: Henry A. Crawford, M.D., President, and William J. Lee, Administrator, of the Ohio State Medical Board. (3) Left to right: Robert E. Rinderknecht, M.D.; George W. Paulson, M.D., and Janet K. Bixel, M.D. (4) Left to right: Joseph L. Logan, M.D., and C. Edward Pichette, M.D.















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Health Care Delivery: The Expensive Role of Government

Stewart B. Dunsker, M.D.

CONCERN FOR HEALTH CARE and its costs has produced much debate and discussion about federal regulation and intervention, or the lack of it. Individuals feel threatened by the possibility of the loss of health with resultant medical and financial catastrophe. The problem of delivering health care to the greatest number of individuals at the most economical cost deserves — and requires — the utmost of our objectivity and judgment. The decision on how to ameliorate this problem will be made by politicians, but the people of the United States must control those decisions that will regulate their access to health care and which may drink their tax dollars.

Cries demanding changes in the health delivery system have been heard from many corners. However, change without progress not only serves no purpose but it wastes energy and dollars. To improve our status, we must first identify the problems, then analyze them, and reach solutions. There is reason to believe, however, that the citizens of the United States, the health care consumers, have been fed half truths from which incorrect problems have been identified and erroneous solutions proposed. Because the health care consumers are asked to judge the health industry as well as to participate in health care planning, they should be given all of the facts.

Incorrect Identification of Problem

The fact that health care costs soared to $120 billion in 1975 is cited as a problem. This is a source of concern — not a problem. Two problems should be recognized regarding this statement:

1. What can be done to diminish the rate of escalation of health care costs? (It will be shown later that, in spite of its best intentions and concern, the federal government has neither the power nor the ability to stop the escalation. Moreover, the government has never succeeded in permanently reducing costs on items it purchases.)

2. How much health and medical care can, and should, be bought for $120 billion.

Dr. Dunsker, Cincinnati, Staff Member and Associate Director, Neurosurgical Training Program, Christ and Good Samaritan Hospitals; and Instructor in Surgery, University of Cincinnati College of Medicine.

Submitted November 29, 1976.

Partial Truths that Have Led to Erroneous Conclusions

It has been demonstrated that economically deprived areas of communities are filled with increased disease. But it has been claimed that the rate of disease increases because people cannot afford medical care. It was concluded, therefore, that more physicians must be supplied to improve the lot of these disadvantaged individuals.

If residents in the richer suburbs are healthier, then how much more often should the ghetto residents visit physicians to improve their health? In a study completed by the Department of Health, Education, and Welfare,[1] it was determined that individuals between the ages of 18 and 65 years see physicians as often in the ghetto as they do in richer suburbs. Those persons in the ghetto who are younger than 18 and older than 65 years do see physicians slightly less than those in more affluent neighborhoods, but the differences are statistically insignificant. Therefore, the lack of availability of medical care is not directly responsible for the increased rate of disease and death in poorer areas.

There is no debate that there is an increased amount of disease in the ghetto, but an incorrect analysis of the problem will inevitably lead to erroneous solutions. In the past, the problem was met by the federal government merely supplying dollars to enable the poor to buy medical care. As should have been expected, that effort failed to reduce the incidence of disease. It has been recognized that the increase of disease in the ghettos is related to environment and social conditions.[2,3] Reduction of disease is dependent upon the application of preventive medicine techniques and not applied medicine. If, out of our concern to improve the health of the economically disadvantaged, we again select the wrong solution and only have increased numbers of physicians working in the ghetto areas, we will again wash more dollars down the drain and witness another expensive campaign that is destined to fail.

It has been claimed that because health care costs have increased faster than any other item on the consumer price index, the cost of medical and health care can only be controlled by federal regulation of costs, services, and physicians' fees.[1] The discrepancy in this theory should be very obvious. Figure 1 shows a comparison of the consumer price index (CPI) average compared to the consumer price index average of medical costs. There is

no question that medical costs have risen higher than the CPI index average. But the CPI average is a composite of such diverse items as string beans, haircuts, and medical costs. Figure 2 compares physicians' services to service items on the CPI, and the items are directly comparable. However, hospital costs have skyrocketed and are recognized as the culprit directly responsible for the severely increased costs of medical care. This is seen more clearly in Figure 3, which is a composite of these two graphs.[4] In contrast to some reports, physicians' fees are not the most expensive item on the consumer price index. They are well below the cost of food and fuel, repair services, and especially, legal services, which are almost the highest item on the entire CPI (Fig. 4.)[5,6]

If the exorbitant rising cost of medical care is not attributable to physicians fees, but to the costs of hospital care, why have the hospital costs risen? As expected, population growth and inflation played significant roles in increasing hospital costs. In addition, increased labor costs accounted for a large share of the increase* To provide better medical care from 1950 to 1972, the number of employees per patient in hospitals was almost doubled. In addition, we now have services such as renal dialysis, open heart surgery, kidney transplants, and cardiac care units, which were not routinely available ten years ago. In contrast to industry, increase in medical technology is not designed to save labor but to prolong life and health. These services supply more sophisticated medical care, but that increased care requires more highly educated and skilled technicians and costs more to develop and implement.[4]

In analyzing the consumer price index (CPI), there is a great difference between comparing items of medical costs and every other item on the index. It is a well-recognized fact in government publications[1,4] (but rarely disseminated or discussed) that *medical care costs are the only items in the entire CPI that are not adjusted for quality.* No one knows how to make the adjustment for increased quality and for new and improved medical services: every dollar spent on a new or improved service in medical care is listed as a dollar of increased cost. Therefore, the consumer price index, *by design,* exaggerates increased costs in medical care.

The most important factor responsible for increased hospital costs is hospitalization insurance which has increased the demand for sophisticated health services.[7] Conversely (and politically unpopular to admit), the greatest regulator of hospitalization use is out-of-pocket expenses. In 1950, out-of-pocket costs per hospital day were $16; in 1972, they were $18.50 in 1950 dollars, and this represents a net decrease to the patient.[7] In its five-year plan,[1] the Department of HEW recognized that the greatest impetus to increase medical and hospital costs was increased demand in utilization of services stimulated by Medicare and Medicaid. It should have been no surprise to the federal government that when they increased demand, they caused an increase in the costs of these items. Consequently, it should be obvious that all programs that propose complete first-dollar coverage (the Kennedy-Griffiths Bill for comprehensive, total, national health insurance) are destined to increase the demand for hospital and medical services beyond the country's economic resources to pay for them.

Various proposals have been made in Congress for systems of comprehensive national health insurance to pay for medical care. Before accepting any such system, we must realize that we are not blazing a new trail. We could learn what has transpired in other countries with

(continued on page 505)

*From 1960 to 1975, labor accounted for 60 percent of the hospital budget and 34 percent of the increased costs.

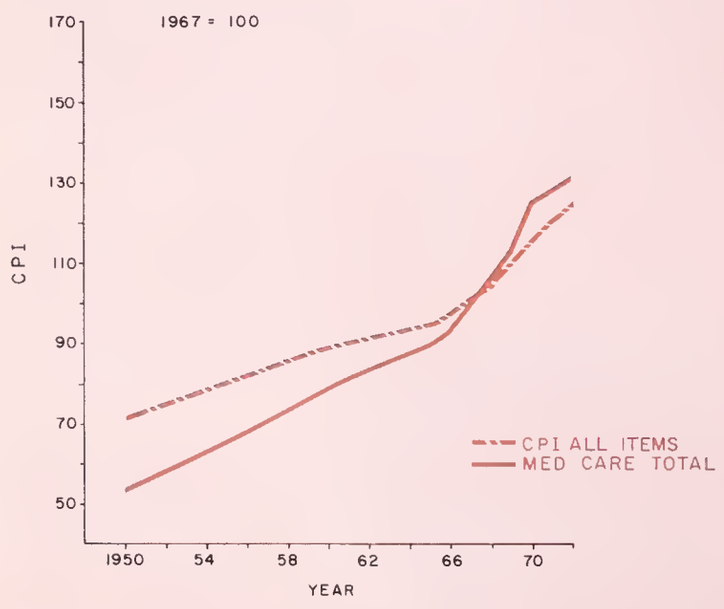


FIG. 1. Average annual indexes for consumer prices compared to medical care.[4]

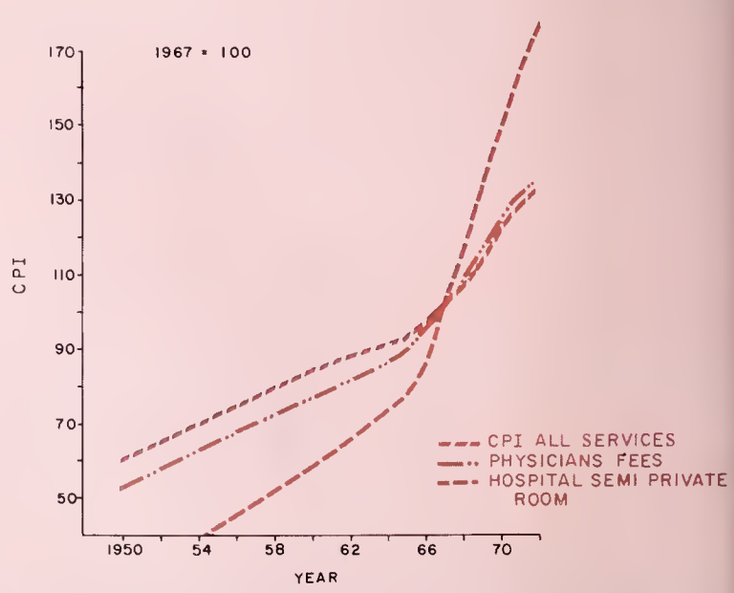


FIG. 2. Average annual indexes for consumer prices compared to medical care including physicians' fees and semi-private hospital room charge.[4]

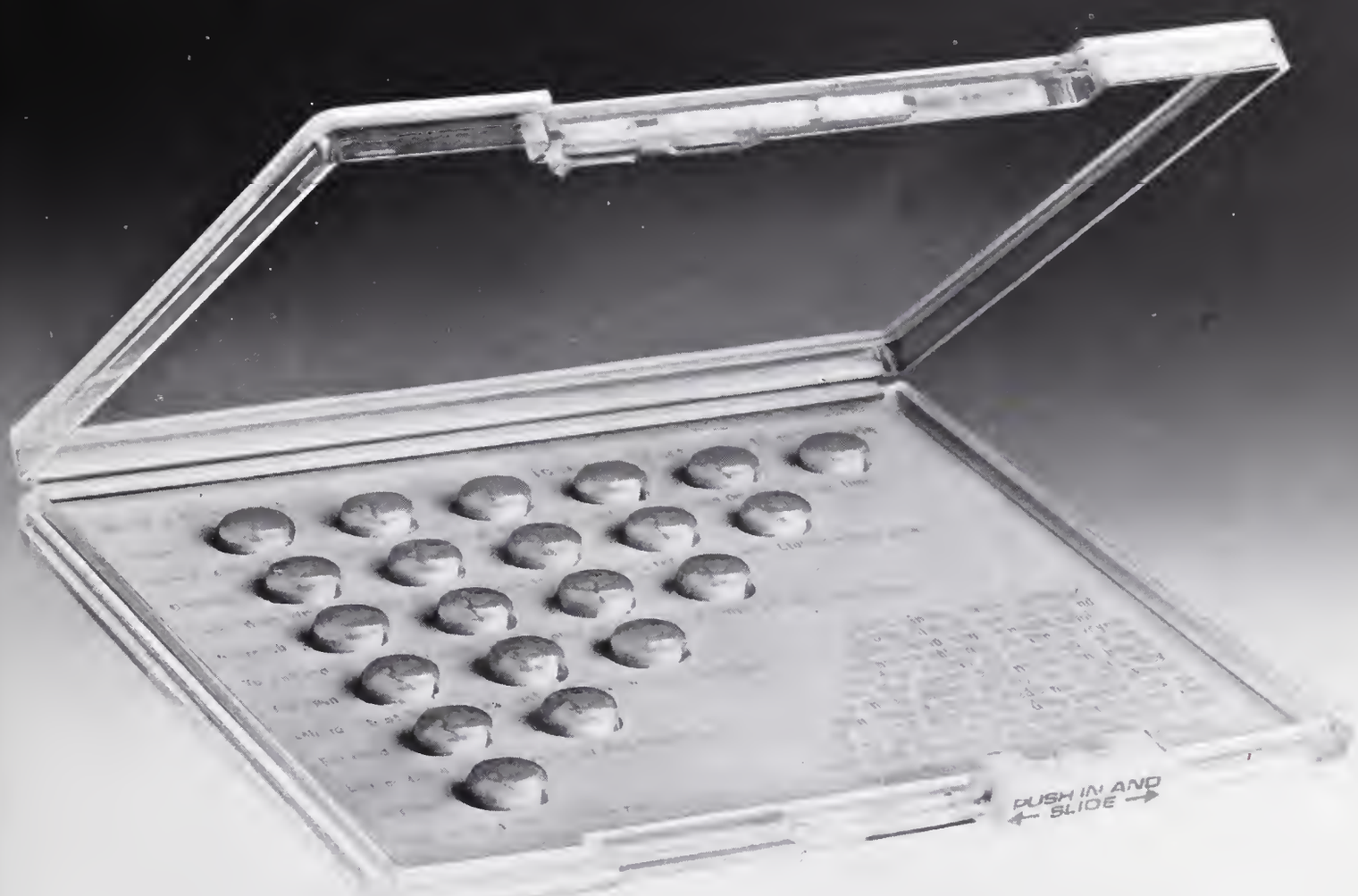
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comprehensive health coverage. From 1970 to 1974, health care costs rose 25 percent in the United States (Fig. 4), but they rose 40 percent in Sweden.[5] Only in Canada, Italy, and France did health care costs rise slower than in the United States. Although medical care costs rose at an alarming rate in the United States, they went up less than in those countries with a total-government-paid system. Therefore, we should reexamine the fee-for-service system which was obviously responsible for keeping the cost as low as it did in this country.

Some articles have stated that our present system has not delivered quality medical care. They used international statistics on infant mortality rates to show that the United States ranks far below Sweden, implying that a national health system would produce better health care. The same articles fail to point out, however, that Sweden had the lowest international infant mortality rate in 1955, *before* it had a national health plan.[8] Its infant mortality rate is related to its small, homogenous population — not to its national health plan.

It should be very upsetting to both the politicians and the citizens that the most expensive item in our society today — taxes — is not even listed on the consumer price index. In 1974, a moderate income was listed at $12,626, and the largest single increase compared with 1973 was taxes, as shown below:

	Increase
Taxes	$426
Social Security	140
Food	379
Housing	393
Transportation	145

Taxes increased 12 percent more than food.[9] In New York, for every dollar increase in salary, 43¢ went for taxes.[10] There is no question that the burden of increased government expenditure falls on the middle class citizens, who comprise the largest percentage of our working population.[13] In Sweden, Norway, Denmark, and the Netherlands, where there is comprehensive national health insurance, taxes represented more than 42 percent of the gross national product in 1971. In 1971, in the USA, taxes represented only 28 percent of the gross national product. The average wage earner in Sweden pays 40 percent of his income to finance multiple social programs.[12] We can only conclude that the proponents of comprehensive national health insurance would like (and plan) to raise the income tax of the average worker to 40 percent.

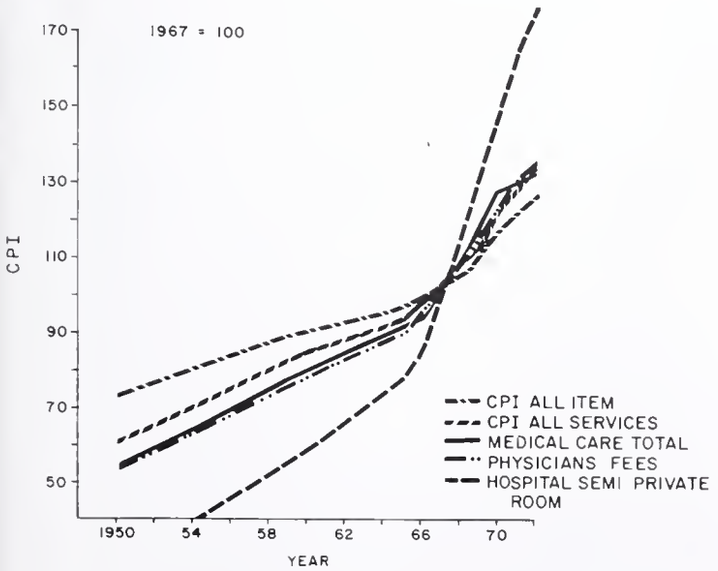


FIG. 3. Composite of indexes shown in Figs. 1 and 2.[4]

Increased Hospital Costs

The President's Council on Wage and Price Stability Report of April 15, 1976[13] stated that the costs of hospital and physicians' services increased more than any other single item on the consumer price index in 1975. That same government report recognized two other features which, unfortunately, have been kept in obscurity. The first is that the increased charges by physicians and hospitals reflect only increased costs they faced — they do not represent more profit. A significant portion of these increased costs go directly to purchase liability insurance. As long as the public and Congress remain complacent about the liability and malpractice problem (assuming that this problem only affects physicians and hospitals), expenses will rise and will be directly responsible for the ever-increasing cost for needed medical care to the average consumer. Second, who bears the brunt of any increased taxes that may be levied for more services? In the United States, the vast majority of our citizens are in the economic "middle class." Therefore, even with progressive taxation (wealthier individuals pay more taxes), the very large middle class will continue to pay the majority of any new taxes.

Government Waste

The government finally has recognized that the infusion of more purchasing power without prepared changes in the system would only aggravate the present financial problems.[1] Government control of the health sector will not reduce costs; it will only intensify the problem of rapid escalation and expense.

Despite the loud cries of those in the federal government that the health industry is irresponsible in controlling its costs, a closer look at programs run by the federal government causes even greater concern. Federal agencies have a continuing theme of wasting dollars. A high official of the Department of Health, Education, and Welfare admitted that the agency wastes $1 billion a year in only one of its programs.[14] In 1975, the Social Security Administration had a computer error in overpayment of $404 million.[15] This type of wastage cannot be allowed to continue. The federal government has been so inefficient in administering its Social Security plan that municipalities and state agencies are withdrawing from its roles. It is no secret that the Social Security Administration, despite the denial of the Social Security Agency, is nearly bankrupt and pleading to Congress for more funds from general revenues.

(continued on page 506)

The federal government not only has been inefficient in the administration of its agencies, but it has a proven history of gross inaccuracy in predicting the costs of programs. When Medicare was enacted in 1965, it was estimated that the insurance program for payment of hospital bills would cost 1.23 percent of taxable payroll up to $6,600 annually during the life of the 25-year cost estimate. After only three years, it was obvious that the estimates were grossly inadequate, and it was necessary to increase the cost to the taxpayers to 2.27 percent of a taxable payroll based on $7,800. Reviewing this in dollars of costs in 1965, it was estimated that the annual cost in 1970 would be $3.1 billion. By the beginning of 1970, this estimate was raised to $5.8 billion, which is an 87 percent error in estimating.[18] To warn the government that their prediction was wrong, a statement was presented to the Committee on Ways and Means by the American Medical Association (AMA).[17] The reward for making that unpopular, but more accurate, statement was that the AMA was called obstructionist and reactionary. With the government's poor record of economic prediction regarding Social Security and Medicare, there is good reason to question the Kennedy-Griffiths Bill for comprehensive national health insurance which estimates that the cost of total comprehensive national health care will be $13 billion per year.[18] Using past government inaccuracies, that estimate probably represents a minimum true cost of over $24 billion annually *to start.*

Lack of Responsibility in Government Plans

Not only is there a history of government wastage, inaccurate predictions, and inefficient administration of agencies, but there is evidence that the government has been irresponsible in formulating its own plans for the future increased delivery of health care. In the five-year plan of the Department of Health, Education, and Welfare, it was stated and recognized that the major problems of the future are locked into the prevention of illness.[1] However, the major factors involved in these preventions necessitate changes in life style including smoking, diet, and housing. The government has recognized this, but because it is difficult to cope with these factors, *it plans to ignore them.*

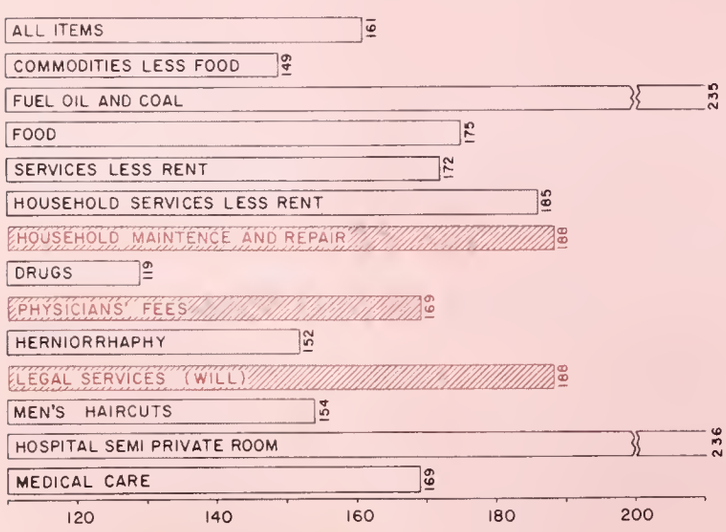


FIG. 4. Consumer price index 1975 average[5,6]

The special initiatives of prevention which it plans to undertake affect a minority of illnesses, medical conditions, and unproven problems that will have no effect on diminishing disease, increasing longevity, decreasing infant mortality rates, or diminishing costs. It plans to increase the capacity for laboratory diagnostic technology for periconceptive disease. It plans a national program of fluoridation of water which is estimated to save only $2.6 billion in 15 years. They plan to investigate occupational carcinogenesis, which may be important but has no proven role in the majority of cases of carcinoma that we now treat. They plan to strengthen local community capacity to deal with environmental health problems and to conduct toxicologic research. In addition, they plan comprehensive immunization programs and development of a coherent set of health education initiatives. There is no question that these items are of probable importance. However, not one of them will play a major role in controlling our current problem of skyrocketing hospital costs which are of immediate concern and danger to the financial stability of this country. Nor will they affect the immediate longevity rate or the infant mortality rate so often referred to.

Possible Government Role

In 1965, Congress declared that health care is a right, but Congress failed to recognize that the *delivery* of health care is a resource and, like all resources, it is not infinite and must not be wasted. We must determine by priorities what it should be used for. If the federal government has decided irrevocably that it must, and will, enter the arena of health care delivery, then it should announce its priorities for national concerns; establish a means for the evaluation of honest, cost effectiveness of its own programs; and perform an objective review of health system agencies so that it and all other programs are accountable. Organized medicine has long used the system of peer review for the determination of performance. The concepts of peer review and accountability used in medicine, addressed by politicians and referred to by bureaucrats, are conspicuously absent from the committees of the Congress, the departments of the Cabinet, and the local health planning agencies.

Rather than launch massive new programs, each heralded by its advocate as the panacea for a problem, it would be more reasonable to establish pilot projects, eg, study of new methods of health care delivery to physician-poor areas as in some rural and ghetto communities. These projects would allow extension of existing facilities without duplication and would demonstrate their own effectiveness or ineffectiveness. This, in turn, will allow us to discard bad projects before many millions of dollars are wasted. The government can use this same system to try to change the harmful aspects of our life style, which are being ignored at present. It can funnel individuals in need of early medical care into existing channels and use the large numbers of physicians already available.

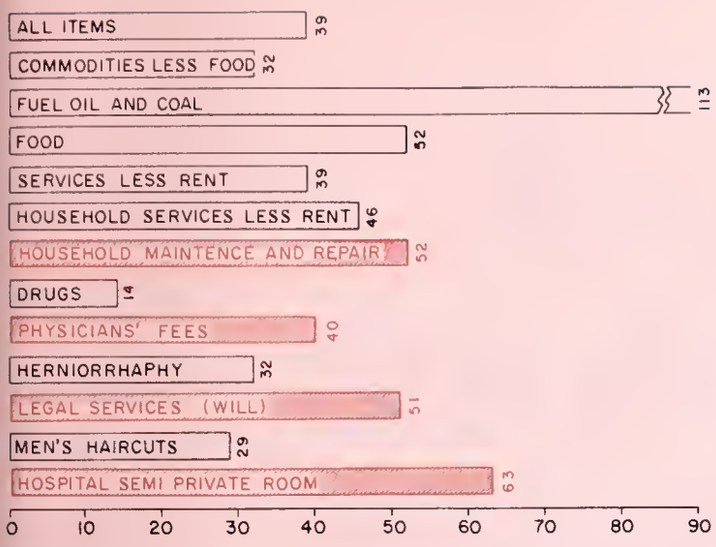


Fig. 5. Percent change in consumer price index 1970-1975 (1967 = 100).

Unquestionably, the easiest — but most irresponsible — way for Congress to resolve the multifaceted problem of economical delivery of medical care would be to enact a bill of total comprehensive national health insurance. This would resolve the issues only by removing them from the congressional agenda, but such a bill would not solve the problems of the rising costs of medical care and the maldistribution of physicians. In the long run, it would usurp more taxes from the average worker to pay for a guaranteed bureaucratic jungle. In seeking answers to the problems, we hope that the congressional committees will not view disagreement by societies of organized medicine as confrontations and obstinacy, but rather as conscientious approaches to a ubiquitous problem. The federal government must use the strengths of the present system as the launching platform for change with progress. If the government only expands its position in medical health care without using the present base, it will continue to use physicians as a scapegoat for which it, in fact, will be responsible.

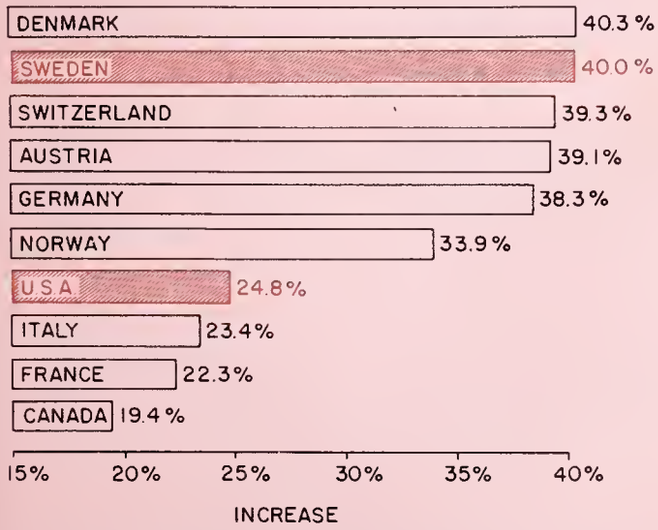


Fig. 6. Percent increase in cost of medical care 1970-1974.[5]

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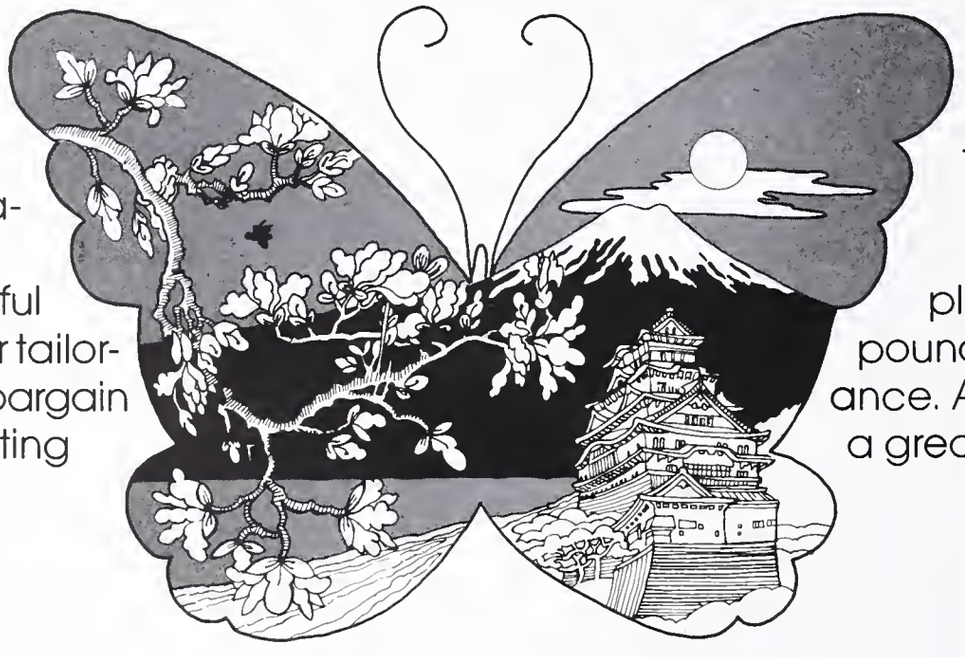
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News *(continued from page 446)*

of errors, and I regret any embarrassment that may have been caused to any of your members." Robert A. Derzon, head of HEW's Health Care Financing Administration, has been given the responsibility of putting out a corrected list.

6th Edition of *Allied Medical Education Directory* Now Available From AMA

The increasing role of trained nonphysician experts in the delivery of health care is emphasized with the publication of the new sixth edition of the AMA's *Allied Medical Education Directory*. Twenty-nine national organizations collaborated with the AMA in compiling the directory of education programs for 26 occupations, ranging from assistant to the primary care physician to urologic physician's assistant.

The directory is a detailed account of 40 years of research and progress on the part of the AMA and the allied national organizations in the area of allied medical education. There is a section on financial aid and descriptions of the 26 allied medical occupations, with information on each accredited program. The accreditation process is explained in detail.

More than 2,700 educational programs accredited by the AMA are listed in the new directory. A separate chapter is devoted to each health career and its educational program. Occupational descriptions, admission prerequisites, and certification information are followed by alphabetic listings of educational program sponsors by state and city.

The directory is available from the Order Department, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60611. The cost is $8.

OSMA Offers Books About Malpractice Study

"Greed" or "people wanting something for nothing" was perceived by almost 41 percent of a random sample of 1,500 Ohioans as the reason for the dramatic rise in the number of malpractice suits being filed. The survey was part of a major research project launched late last year by two Ohio State University Professors of Consumer Behavior, Roger Blackwell, Ph.D., and W. Wayne Talarzyk, Ph.D.

The purpose of the study, conducted under a grant from the OSMA Malpractice Research Fund, was to assess the attitudes and behaviors of consumers concerning health care and physicians. Special attention was given to identifying the types of individuals most likely to bring suits, the reasons for the suits, and what physicians could do to prevent suits. Consumer support for various possible solutions to the malpractice problem was also evaluated.

Two books about the study are available. *Consumer Attitudes Toward Health Care and Medical Malpractice* is directed toward the health care professional; while *Consumers Speak About Health Care,* a brief summary of the highlights of the findings, is for use by the general public. Also available, for purchase or lease, is a complete set of slides illustrating the study accompanied by a cassette and a written script prepared by Doctors Blackwell and Talarzyk. The cassette may be purchased separately.

Both books have received nationwide media attention. All OSMA members have received a copy of the highlights book, and those members who contributed to the Malpractice Research Fund also received a copy of *Consumer Attitudes Toward Health Care and Medical Malpractice.* The books have also been distributed to libraries, schools, federal and state legislators, and other key individuals and organizations.

OSMA members are urged to place copies of *Consumers Speak About Health Care* in their waiting and examining rooms and to distribute them to their new patients. (Use the order blank below.)

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Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

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(EDITOR'S NOTE: The Journal presents the above classified advertisements to its readers as announcements of the physician's assistant and the audiologist and assumes no responsibility for the statements made.)

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(Classified Ads continued on page 514)

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Report on the 1977 AMA Annual Meeting



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AUGUST 1977
Volume 73, Number 8

THE OHIO STATE Medical Journal



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A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

House Passes Laetrile Bill

The Ohio House of Representatives passed House Bill 650 (Sweeney, D-Cleveland) legalizing the manufacture, sale, and administration of amygdalin (Laetrile) in Ohio. The OSMA Department of State Legislation was successful in amending HB 650 in line with the OSMA House of Delegates' mandate of "over-the-counter sale" of Laetrile. Rep. Don Maddux (D-Lancaster) greatly assisted the OSMA by sponsoring the amendment on the House floor to make all forms of Laetrile available "over the counter" without physician's prescription.

Rep. Maddux and Rep. Ronald James (D-Proctorville) sponsored an amendment in committee that requires all Laetrile containers to bear a notice in bold type reading: "The Ohio State Medical Association does not recommend amygdalin (Laetrile) for the treatment of cancer and Laetrile may be harmful to your health."

Rep. Sweeney, the sponsor of HB 650, worked closely with the OSMA and supported the over-the-counter amendment during the intense debate on the House floor. Three other members contributed significantly to the success of the OSMA amendment: Rep. Richard Finan (R-Cincinnati), Rep. Les Brown (D-Columbus), and Rep. Robert Netzley (R-Laura) provided support for Rep. Maddux and turned the tide of strong opposition arguments.

Opponents to the OSMA amendment felt physicians were "copping out" of the Laetrile treatment controversy and, in effect, were failing to meet the responsibility of the medical profession. It was argued that the physician, not the patient, was the most appropriate person to decide whether Laetrile should be used. However, the OSMA House of Delegates' mandate was the "over-the-counter" approach.

The Laetrile bill is now before the Senate Education and Health Committee. The Chairman of the Committee, Sen. Morris Jackson (D-Cleveland), has refused to yield to the pressure from the group supporting HB 650. He has not scheduled a hearing in the Committee on the legislation before the summer recess, believing HB 650 needs a full review by the Senate Committee. Members of OSMA should contact Sen. Jackson and other committee members to explain the dangers of this legislation. (Sen. Morris Jackson, State House, Columbus 43215.)

Anti-Substitution Law Repealed

Senate Bill 45 (Freeman, D-Canton), repealing Ohio's anti-substitution law, was approved by the Ohio General Assembly and was signed into law by Governor James A. Rhodes. Rep. Arthur Brooks (D-Cleveland) offered an amendment to the bill, which becomes effective January 1, 1978, to allow the consumer to realize the alleged cost savings attributable to the substituiton of a generic product. The consumer savings amendment was opposed by the sponsors and promoters of SB 45, the Ohio Pharmaceutical Association and the Ohio Council of Retail Merchants. The Department of State Legislation will be informing OSMA members in detail of the effects SB 45 will have on medical practice.

OSMA Members Called to Action Against Optometric Drug Bill

Senate Bill 163 (Jackson, D-Cleveland), legislation permitting optometrists to administer "diagnostic pharmaceutical agents," was favorably recommended for passage by the Senate Education and Health Committee. Although the Committee recommended the bill sponsored by the Committee's chairman, Sen. Morris Jackson, the battle is not over. The bill now goes to the Senate Rules Committee to be scheduled for a floor vote. The Ohio Optometric Association and its member optometrists have been exerting tremendous pressure on the Rules Committee to vote the bill onto the floor of the Senate.

Personal contacts by physicians will make the difference. The Rules Committee members and your local senators need to hear from all physicians regarding the use by nonmedical practitioners of dangerous drugs in patients' eyes. The Rules Committee plays an important role in the success or failure of this legislation. If the Rules Committee holds SB 163 indefinitely instead of sending it to the Senate floor, the bill will die. Only your contact can keep this bill in Rules.

Talk to your local ophthalmologist about this bill and contact the members of the Rules Committee and your own senator.

Senate Rules Committee

Oliver Ocasek, Chairman (D)
7665 Gannet Rd., Northfield 44067 (216/467-6550)
M. Morris Jackson, Vice-Chairman (D)
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Harry Meshel (D)
786 Fairgreen Ave., Youngstown 44510 (216/747-3245)
Marigene Valiquette (D)
3211 Parkwood Ave., Toledo 43610 (419/243-9773)

Commitment Procedures Revised

The House approved House Bill 725 (Leonard, D-Dayton), legislation revising commitment procedures and mental patients' bill of rights contained in last session's HB 244. On the whole, Rep. Leonard has put together a practical solution to the problem HB 244 has created in the treatment of mentally ill persons. The bill simplifies the commitment procedure by permitting physicians to testify in commitment proceedings by written deposition, providing it contains adequate evidence. Furthere, HB 725 makes the probable-cause hearing an informal hearing rather than the adversary courtroom situation created in HB 244. The bill now goes to the Senate.



the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Talmadge Proposal

Congress has held hearings on legislation proposed by Sen. Herman Talmadge (D-Ga.) that would institute a prospective reimbursement plan for the nation's hospitals. The Talmadge bill is considered a rival of the Administration's proposal to place a nine percent "cap" on hospital revenues.

The Administration told the Senate Finance Subcommittee on Health, headed by Talmadge, that it likes some provisions of the Talmadge bill but that it is imperative that the controversial "cap" proposal be enacted, perhaps with features of the Talmadge bill included.

Most health provider groups, including the American Medical Association, found the Talmadge plan much more palatable than the Administration's bill, though they took issue with some of the Talmadge provisions.

Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees, told the Subcommittee: "We commend the sponsors of this legislation for its broad coverage of a variety of issues in the Medicare and Medicaid programs." While there are some provisions the AMA does not support, "there are many others which we believe would be beneficial and for which we urge your favorable consideration," Dr. Holden testified.

The Administration's arbitrary ceiling or "cap" on total hospital revenues "lacks appropriate flexibility, provides disincentives for efficiency and in fact would reward inefficiency," said Dr. Holden. "Most importantly that proposal would impact unfavorably most directly upon the continued provision of quality care."

The Talmadge provisions "attempt to meet the hospital cost problem in a more positive and equitable manner than that of the Administration," Dr. Holden said. "However, notwithstanding our belief that the Talmadge bill is a more realistic program, we do believe that adoption of the program in the manner presently proposed could have uncertain and perhaps even undesirable effects."

"Risks of any single new program imposed nationally are not warranted at this time especially when there are other potential alternatives which merit similar consideration," Dr. Holden said. "Experiments with various reimbursement methods have not been fully implemented and evaluated. We would recommend that the cost containment incentive program of this bill be the subject of experiment and demonstration in a limited geographic area before being considered for nationwide application. We feel that all interested parties would benefit from such a procedure."

The AMA witness termed "beneficial" another provision encouraging the voluntary elimination of underutilized beds and the closing of facilities or parts thereof.

Dr. Holden said "we also recognize the problem of increasing health costs and are seeking solutions." He noted the AMA's establishment of a National Commission on the Costs of Medical Care.

Also appearing for the AMA was Edgar T. Beddingfield, Jr., M.D., Chairman of the AMA Council on Legislation. Dr. Beddingfield said several provisions of the bill on physician reimbursement "could have a detrimental effect on the availability and quality of care." The proposed creation of a special class of practitioners, designated as "participating physicians," though somewhat modified this year, would still cover those who agreed to accept all Medicare reimbursement for their services on the basis of assignments. Inducements such as simplified claims procedure would be offered to encourage physicians to become "participating physicians."

Dr. Beddingfield said the proposal "does not reach the issue of why assignments are not widely accepted. The major deterrent to assignments is the insufficient reimbursement rate under Medicare and this proposal does not correct this problem."

Also criticized was the proposed Talmadge criteria for determining Medicare reasonable charges for physicians' services which would allow the government to determine statewide prevailing charge levels for each state, based on 50 percent of the charges made for similar services in the state. Prevailing charge levels in a locality would continue to be subject to an economic index, but any increase in the prevailing charge level could not exceed the statewide prevailing charge by more than one-third.

"The real effect of this change," Dr. Beddingfield said, "would be a further restriction on reimbursement levels in the state achieved primarily through a reduction in the already limited increases which would otherwise be allowed under the Medicare Economic Index."

The Administration has damned the Talmadge bill with faint praise. Recognizing that Talmadge's measure poses a serious threat to the Administration's controversial Hospital Cost Containment Plan, HEW Secretary Califano devoted a great deal of his testimony during the hearings to plugging the Administration's approach. He had praise for some facets of the Talmadge bill, expressing the hope that two approaches could be melded, but this criticism of the key prospective hospital reimbursement provision was so strong that a marriage may be difficult.

Califano said that the Talmadge reimbursement plan suffers from lack of available data and methodology to put it into effect. "Further, it only covers about 30-50 percent (Medicare-Medicaid) of present hospital costs, and will not, in our judgment, effectively control costs in the immediate future," said Califano.

The Talmadge plan could cost up to $50 million more next fiscal year, in contrast with the estimated national savings of $1.9 billion for the Administration's Hospital Cost Containment Act, according to the Cabinet Officer.

"We feel strongly that the problem of rising costs is of such disastrous proportions that we simply cannot wait for a perfect solution before acting," Califano testified.

He said the Administration supports the concept of prospective reimbursement of hospitals, but "holding down Medicare and Medicaid payments alone could simply encourage hospitals to refuse these patients, to provide such patients with second-class care, or to transfer their costs to other payors."

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COVER: Medicine has two fine leaders in OSMA President William M. Wells, M.D., Newark, and AMA President John H. Budd, M.D., Cleveland. Harry K. Hines, M.D., Ohio Delegate to the AMA from Cincinnati, shot this photograph on the roof garden of the Fairmont Hotel, San Francisco, during the 1977 AMA Annual Convention. The Academy of Medicine of Cincinnati and Hamilton County will feature a showing of Dr. Hine's photographs during September. A complete report of the 1977 AMA Annual Convention begins on page 524 of this issue.

THE OHIO STATE Medical Association News

OB/GYN College Releases X-ray Guidelines for Fertile Women

The American College of Obstetricians and Gynecologists has approved new "Guidelines for Diagnostic X-ray Examination of Fertile Women." The guidelines were developed by the College, in consultation with the American College of Radiology, in response to recent questions in both the lay press and scientific literature concerning the degree of risk in x-ray of fertile women, the need for such x-ray, and means for minimizing the risk.

According to the *ACOG Newsletter*, June 1977, the policy statement offers these three basic guidelines for use of diagnostic x-ray of fertile women:

1. The use of x-ray examinations should be considered on an individual basis. Concern over harmful effects should not prevent the proper use of radiation exposure when significant diagnostic information can be obtained. Preexamination consultation with a radiologist may be useful in obtaining optimal information from the x-ray exposure;
2. There is no measurable advantage to scheduling diagnostic x-ray examinations at any particular time during a normal menstrual cycle; and
3. The degree of risk involved in an x-ray examination if the person is pregnant, or should become pregnant, should be explained to the patient and documented in her record.

Darvon Now Controlled Drug

As of March 14, 1977, physicians dispensing Darvon (dextropropoxythene) or generic equivalents must comply with parts 1301 and 1311 of Title 21 in the Code of Federal Regulations. Physicians dispensing or prescribing this drug will be required to meet the same standards that they do with other Schedule III and IV controlled substances. At the present time, phenobarbital, phentermine, and phendimetrazine are examples of Schedule III and IV controlled drugs.

Insurance Co. Reduces Premiums

A second major premium reduction for its malpractice claims-made coverage was announced this month by Medical Liability Mutual Insurance Company of North Carolina.

The rate reductions— the first was in October 1976— have resulted in overall premium reductions of about 50 percent.

James E. Davis, M.D., president of the company, cited as reasons for the cuts the support of the medical profession, operating efficiencies, reductions in the rate of increases in claims and awards, and the company's stated purpose of providing competition and reducing rates when warranted. The company is sponsored by the North Carolina Medical Society.

Medical Board Activity

The following is a list of activities and actions undertaken from May 1, 1977 to May 31, 1977 by the Ohio State Medical Board.

LICENSURE ACTIVITY		
American and Canadian Graduates		
Licensed by Endorsement	M.D.	64
	D.O.	5
Licensed by Examination	M.D.	0
	D.O.	0
Foreign Medical School Graduates		
Licensed by Endorsement		27
Licensed by Examination		0
Sept. 1972 FLEX Board Policy Licenses		3
Endorsements to Other States	M.D.	46
	D.O.	3
ENFORCEMENT ACTIVITY		
Formal Citations Issued		0
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act		5
Voluntary Surrenders of Medical Certificates		0
Arrests for Alleged Illegal Practice of Medicine		0
Formal Hearings on Alleged Violations of the Medical Practice Act		2



THE OHIO STATE MEDICAL BOARD *LEFT TO RIGHT:* **Row One**— Henry A. Crawford, M.D., President; Peter Lancione, M.D., Vice President; and William J. Lee, Administrator. **Row Two**— Walter Paulo; Sanford Press, M.D.; Henry G. Cramblett, M.D.; John D. Brumbaugh, M.D.; Evelyn Cover, D.O.; and Roland A. Gandy, Jr., M.D. **Not Shown**— Anthony J. Ruppersburg, M.D., and Norman O. Rothermich, M.D., newly appointed member.

(News continued on page 522)

contains no aspirin

tablets

Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

Lilly

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"In a real dark night of the soul
it is always three o'clock in the morning."
—F. SCOTT FITZGERALD
THE CRACKUP, 1936

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1 Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

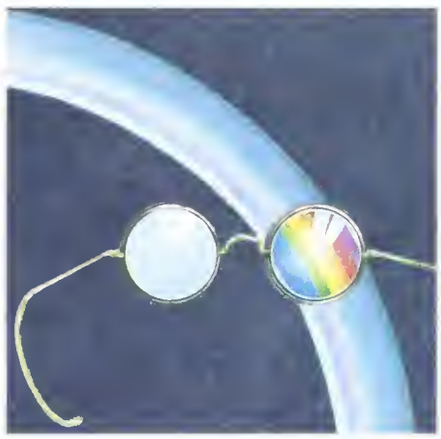
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

News *(continued)*

Hawaii Repeals Mandatory Malpractice Insurance Statute

Hawaii's 1976 law requiring all physicians to carry malpractice insurance and to participate in a state patients' compensation fund has been repealed by the state legislature.

Governor George Ariyoshi signed into law a bill eliminating the mandatory insurance provision of Hawaii's medical malpractice law. The new measure makes many other changes in the old statute, including the elimination of the arbitrary limit on attorneys' fees in malpractice cases. The court will now award these fees on an individual basis.

Another bill signed into law by Gov. Ariyoshi establishes a method under which physicians and other health care providers can form their own cooperative insurance trust fund. The law allows groups of at least 250 physicians to set up their own cooperative, contributing $20,000 each to create a $5-million trust fund to pay for malpractice claims.

The new law continues the state-operated patients' compensation fund for those who wish to participate. Physicians and hospitals who take part are required to maintain a minimum of $100,000 of malpractice insurance, with the fund paying for most claims that exceed that coverage.

AMA Membership Over Expectation

The 1976 AMA dues-paying membership totaled 172,830, exceeding expectations in the first year of a major dues increase. Because of the new dues structure, the AMA based its 1976 budget on a paid membership of 144,500 (excluding residents and students). This full-dues membership figure reached 152,160 last year. Resident membership was 10,506; medical students numbered 10,164. Total AMA membership, including dues-exempt physicians and affiliate members, was 203,584 in 1976.

AMA officers and staff were commended by the AMA House of Delegates at the June 1977 meeting for fiscal responsibility. (See the AMA report contained in this issue.)

The average age of AMA dues-paying physician members in 1976 was 48.9 years, according to the AMA's Center for Health Services Research and Development. The average age of all United States physicians was 46.3 years in 1976.

Revised HMO Regulations

The Department of Health, Education, and Welfare has announced revised regulations governing health maintenance organizations (HMOs). The revised regulations are geared toward making HMOs more competitive in the health marketplace. In brief, the regulations will make it easier for developing HMOs to obtain federal grants, eliminate mandatory supplementary health benefits, ease the requirement for mandatory open enrollment, and allow loan guarantees to be made to non-profit organizations.

Overheard

With thanks to the Medical Society of the County of New York:

A remark overheard recently in the doctors' lounge of a local hospital: "What makes the government think it can deliver health care when it can't even deliver the mail?"

Congress Rejects FTC Plan

Congress rejected a bill to extend the power of the Federal Trade Commission (FTC) over non-profit associations. The House Commerce Committee voted to continue the exemption of non-profit groups from the formal jurisdiction of the FTC, and the Senate Commerce Committee deleted the provision from its version of the bill. The AMA testified against the bill after a House subcommittee had approved the measure.

California Supreme Court to Rule On State's Malpractice Law

The California Supreme Court has been asked to rule on the constitutionality of the state's malpractice law, which went into effect December 1975. The request came in the form of a petition filed by the state's attorney general on behalf of a bipartisan group of California legislators who had worked for passage of the legislation. The law includes a $250,000 limit on recovery for pain and suffering, a provision for periodic (rather than lump-sum) payment of awards, and a shortening of the time by which a patient must bring a malpractice suit.

Since the malpractice law went into effect, the state's insurance commissioner has refused to order a reduction in malpractice insurance premiums, claiming that the 1975 law, on which such a rollback would be based, might be unconstitutional. The petition for a supreme court hearing also asks that the insurance commissioner be ordered to hold hearings to determine whether malpractice insurance premiums are "excessive" under California law.

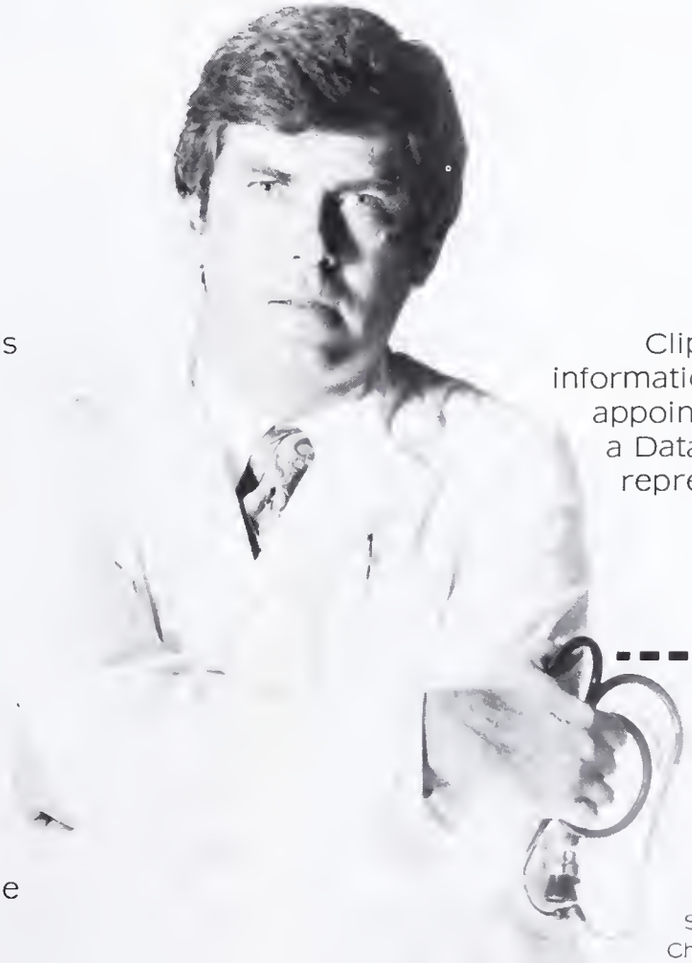
Paperwork Complaints May Be Registered With Government

General complaints about burdensome federal paperwork requirements can be called in to the Federal Paperwork Commission. The toll-free number is 800/424-9882. Not geared to handling individual paperwork problems, the Commission's ombudsmen can assist in complaints concerning duplicative information, excessive manhours used in filing forms, unncessarily complex rules, and overly stringent reporting requirements.

(News continued on page 575)

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It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

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Report on the 126th Annual Convention of the American Medical Association

June 18-23, 1977, San Francisco, California

H. William Porterfield, M.D., Delegate

The 1977 Annual Convention of the American Medical Association was clearly an Ohio occasion, as a number of physicians from the Buckeye State played integral roles in the convention. The highlights of the meeting were the inauguration of John H. Budd, M.D., Cleveland, as President of the AMA and the presentation of the AMA's Sheen Award to Columbus surgeon Robert M. Zollinger, M.D. (See this issue page 528 for Dr. Budd's message to Ohio physicians and page 540 for his Inauguration Address. Also, see page 545 for a Special Article by Dr. Zollinger.)

The Ohio State Medical Association also successfully ran several candidates for AMA office. Cincinnatian Richard T. F. Schmidt, M.D., President of the American College of Obstetricians and Gynecologists, was reelected to the Council on Scientific Affairs; and John W. Moses, M.D., Akron, was reelected to the Council on Medical Education. The Council on Continuing Physician Education elected John E. Albers, M.D., to be its chairman. Also, John R. Beljan, M.D., Dayton, and Richard M. Steinhilber, M.D., Cleveland, were elected alternate delegates from the Sections on Medical Schools and Psychiatry, respectively.

A hotly contested race ensued for the position of Vice Speaker of the AMA House of Delegates. Ohio Delegate W. J. (Jack) Lewis, M.D., Dayton, who is also OSMA Councilor of the Second District, was defeated only after a run-off with Harrison Rogers, M.D., Atlanta, Georgia. Dr. Lewis was involved in the run-off after the initial balloting resulted in James Davis, M.D., of North Carolina being dropped as the third man in the race of three.

As if these were not enough Ohio acomplishments, the Ohio State Medical Association Auxiliary was honored for being first in total American Medical Association Education and Research Foundation contributions in the north central United States and second nationally.



LEFT TO RIGHT: Robert M. Zollinger, M.D., accepts the Dr. Rodman E. Sheen and Thomas G. Sheen Award from AMA President Richard E. Palmer, M.D. (Photo by Joe Fletcher, AMA Staff.)



LEFT TO RIGHT: John H. Budd, M.D., is sworn in as President of the AMA by Chairman of the Board of Trustees Raymond T. Holden, M.D. (Photo by H. William Porterfield, M.D.)

Dr. Zollinger Receives Sheen Award

The AMA House of Delegates officially opened on Sunday afternoon, June 19, with the spotlight of the session on Robert M. Zollinger, M.D. Dr. Zollinger received the 1977 Dr. Rodman E. Sheen and Thomas G. Sheen Award of the American Medical Association. This award is presented annually to a United States physician for scientific accomplishment. It consists of a $10,000 stipend and a plaque. Selection of the candidate is made by the Awards Committee of the AMA Board of Trustees.

In its booklet about 1977 award recipients, the American Medical Association commented:

During his distinguished career, Dr. Zollinger has made major contributions to graduate surgical education and to research in the areas of gastrointestinal physiology, pancreatic pathology, and endocrinology. His best known research investigation dealt with the relationship between the non-beta islet cell tumors of the pancreas and ulceration of the gastrointestinal tract, which is known in the world medical literature as the "Zollinger-Ellison Syndrome."

Dr. Zollinger has been the author or coauthor of more than 280 publications, including *The Atlas of Surgical Operations,* and served as Editor-in-Chief of the *American Journal of Surgery* and as a member of the editorial boards of several medical journals. He was Chairman of the Department of Surgery of The Ohio State University College of Medicine from 1947 until his retirement in 1974. He is currently Professor Emeritus of Surgery.

Robert N. Smith, M.D., Toledo, Honored

During the opening session, the House of Delegates passed a commendation resolution for Robert N. Smith, M.D., Toledo, introduced by the Ohio Delegation. Dr. Smith is Assistant Secretary of Defense for Health Affairs,

(continued on page 526)

Photos on page 525 by D. Brent Mulgrew.


POWELL AND MARKET
28
"I stop at the St. Francis"
BAY AND TAYLOR









AMA Report *(continued)*



LEFT TO RIGHT: H. William Porterfield, M.D.; W. J. Lewis, M.D.; Charles E. Jaeckle, M.D.; and John E. Albers, M.D. (Photo by Linda A. Jacobson.)

United States Department of Defense, and a past president of the OSMA.

Also honored during the convention was Ohio's Charles E. Jaeckle, M.D., Defiance. Dr. Jaeckle, who is AMA Delegate from the Section on Ophthalmology, received the Lucien Howe Prize Medal from the Section. Presented since 1926, the medal honors United States and foreign ophthalmologists for outstanding contributions to ophthalmology. Dr. Jaeckle was a founding trustee of the American Association of Ophthalmology (AAO) and was its first secretary, a post which he held for ten years. He was later named vice-president for sociomedical affairs and also served as AAO president.

Ohio's Hudson an AMA Past President

Also during the opening session, past presidents of the American Medical Association were introduced. These include Ohio's Charles L. Hudson, M.D. A Clevelander, Dr. Hudson was President of the AMA in 1966-1967, and had previously served as president of both the OSMA and the Cleveland Academy of Medicine. Other Ohioans who served in the office are Reuben D. Mussey (1850-1851), George Mendenhall (1870-1871), William W. Dawson (1889-1890), Charles A. L. Reed (1901-1902), John H. J. Upham (1937-1938), and Edward J. McCormick (1953-1954).*



LEFT TO RIGHT: Charles L. Hudson, M.D.; Dr. and Mrs. Budd; and Mrs. Hudson. (Photo by Fletcher.)

OMPAC Receives Leadership Award

The opening session also included remarks from the following: Richard E. Palmer, M.D., President of the AMA; Tom E. Nesbitt, M.D., Speaker of the House of Delegates; Raymond T. Holden, M.D., Chairman of the AMA Board of Trustees; James M. Blake, M.D., President of the American Medical Association Education and Research Foundation; and Rex E. Kenyon, M.D., Chairman of the Board of Directors of the American Medical Political Action Committee.

Dr. Kenyon presented the Ohio Medical Political Action Committee (OMPAC) a Leadership Achievement Award. This award recognized Ohio for having all OSMA officers, councilors, and AMA Delegates and Alternate Delegates as sustaining members of OMPAC.



LEFT TO RIGHT: Robert N. Smith, M.D.; Jerry L. Hammon, M.D.; and Henry A. Crawford, M.D. (Photo by Porterfield.)

Budd Inaugural Musical Event

The inauguration of John H. Budd, M.D., as President of the AMA was performed on Wednesday, June 22, in the Masonic Auditorium in San Francisco. The ceremony was followed by a reception in the Fairmont Hotel for Dr. Budd and his family. During the reception, there was an outstanding jazz performance by some of his many and close jazz friends.

Balloting for officers, held on Thursday morning, June 23, featured the election of Speaker Tom Nesbitt, Nashville, Tennessee, as President-Elect. Dr. Nesbitt is a urologist. Also elected were William Y. Rial, Swarthmore, Pennsylvania, Speaker of the House; Harrison L. Rogers, M.D., Vice Speaker of the House. In the race for trustee, incumbents Daniel T. Cloud, M.D., Phoenix, Arizona, and Hoyt D. Gardner, M.D., Louisville, Kentucky, were reelected. Incumbent James M. Blake, M.D., of New York was not reelected. H. Thomas Ballantine, Jr., M.D., of Massachusetts was also elected on the first ballot for a three-year term. George H. Mills, M.D., of

(continued on page 531)

*Thanks to Dr. Hudson for supplying this list.

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My Fellow Ohio Physicians, The AMA Is Each of Us

A Message From **John H. Budd, M.D., Cleveland,** *President of the American Medical Association*

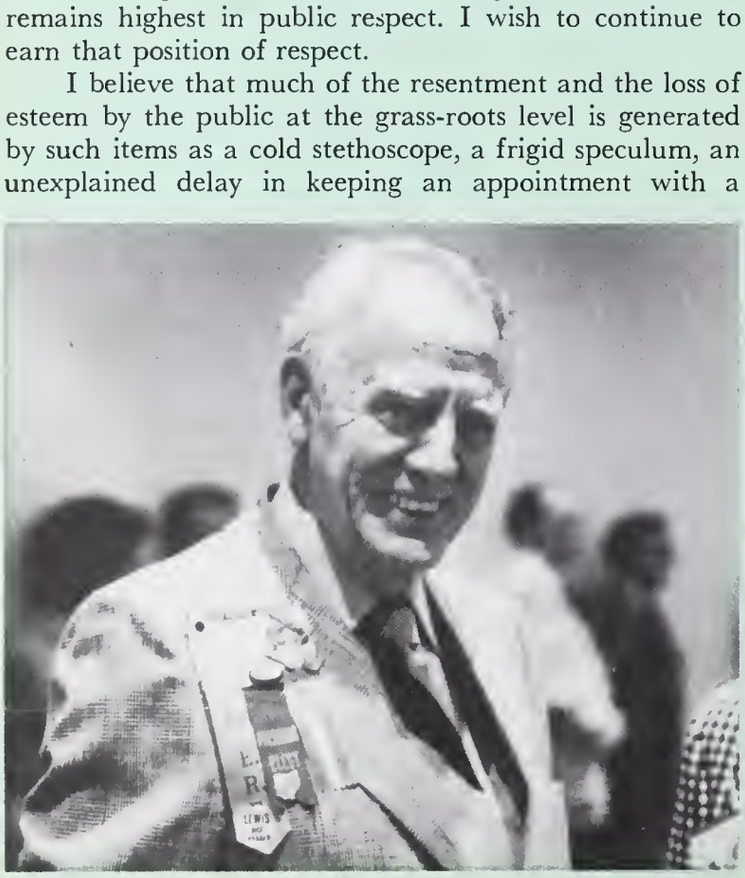
Of all the voluntary social organizations in our country, none are at this time in a position to exert a wider or more important influence over the temporal interests of our country than the American Medical Association.

Nathan Smith Davis, M.D., a principal founder of the AMA, wrote these words in 1855. I believe that they are true today; and as I embark on this presidential year, it will be one of my principal purposes to see that this appraisal remains accurate and that this influence is effectively exerted.

The AMA, with its more than 170,000 dues-paying members, is the largest, finest, and most influential organization representing physicians. However, it is not an isolated, insulated, aloof institution located in Chicago, where policies are conceived and disseminated and, therefore, from which the AMA image emanates. Although the AMA represents the medical profession in the aggregate, the organization is best typified by the face you see in the mirror— the AMA is each and every physician.

Like all of society's institutions, the AMA is under suspicion and challenge for this is the day of the consumer and the skeptic. Business, industry, labor, the media, the dispensation of justice, the educational system, and the government— perhaps especially the government— are diminishing in public esteem. Despite this fall from grace, the medical profession is the one calling which consistently remains highest in public respect. I wish to continue to earn that position of respect.

I believe that much of the resentment and the loss of esteem by the public at the grass-roots level is generated by such items as a cold stethoscope, a frigid speculum, an unexplained delay in keeping an appointment with a patient, a sharp answer to what a patient considered a serious question, or an apparently indifferent attitude toward a patient's concern. This individual experience magnifies into negative reaction to the medical profession nationwide.



John H. Budd, M.D. (Photo by Joe Fletcher, AMA Staff.)

The best spokesman for the AMA is an available, enthusiastic, informed member. In answer to charges that we are self-seeking in our legislative efforts, a member can point out that the AMA has initiated or supported programs to improve health services for rural Americans, migrant workers, American Indians, the emotionally ill, and inner-city dwellers. Drug abuse, veneral disease, alcoholism, and air and water pollution have also been targets for AMA legislative action. Currently, our crusade against excessive violence on television has aroused much interest and approval.

A well-informed member can also assert that the AMA has never sought to limit the number of physicians. Since 1960, the American Medical Association Education and Research Foundation has guaranteed more than 60,000 loans totalling $75 million dollars to medical students, interns, and residents. Also, the same AMA-ERF has contributed $25 million to medical schools in the last 25 years. These funds come largely from donations by individual physicians or the concentrated efforts of their spouses in the Auxiliary.

At times, the public must be informed that there are certain issues against which the AMA must take a strong stand, especially the government assaults on the quality and distribution of health care and the freedom of our profession to provide it to the best of our ability. Examples of AMA efforts are successful resistance to government control of the number and location of residency programs, federal standards for licensure, and violation of privacy in the doctor-patient relationship.

The AMA is presently engaged in a challenge by the Federal Trade Commission (FTC), which insists that a potential conflict of interest exists due to the AMA being involved in the accreditation of medical schools. This, the FTC contends, permits practicing physicians to decide which medical schools shall survive. Totally ignored in this controversy is the fact that approximately 25 new schools have been built in the past 12 years and that the number of medical school freshmen has increased from 7,500 two decades ago to 15,000 today.

We must focus public attention on the comprehensive activities of the AMA, which are virtually always directed toward the benefit of the public. These efforts will enhance the image of medicine during a time when other forces are trying to shrink it. We need an informed AMA membership . . . ready and willing to speak up for medicine.

(AMA Report continued on page 531)

When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



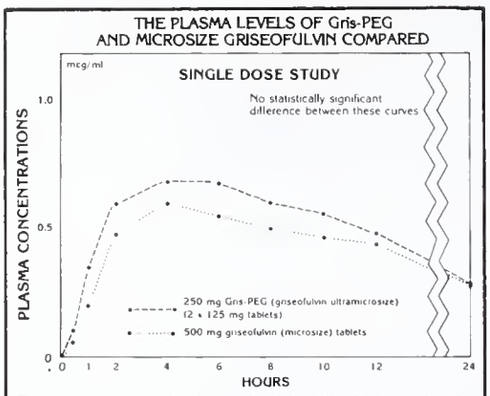
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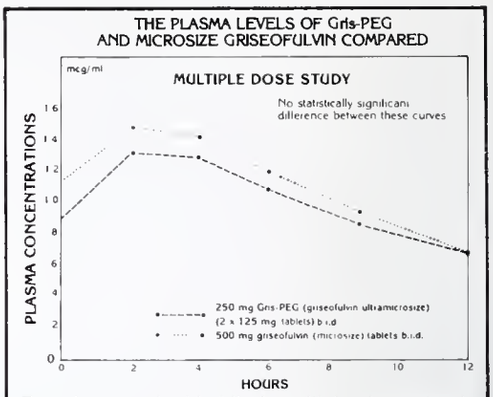
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum, Epidermophyton* and *Trichophyton* It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0 25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1 6 mcg/ml

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE Prior to therapy, the type of fungi responsible for the infection should be identified

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to2 5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy The safety of this drug during pregnancy has not been established

Animal Reproduction Studies. It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities

Proteinuria and leukopenia have been reported rarely Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks, *tinea pedis*, 4 to 8 weeks, *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested. Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YE

AMA Report *(continued)*

Hawaii was elected for the remaining three-year term in a second balloting. This election was followed by Charles Max Cole, M.D., Dallas, Texas, being elected to fill the unexpired term of the late Joe T. Nelson, M.D., in a race between Dr. Cole and the resident-physician candidate, William Mangold, M.D.



John H. Budd, M.D., at the piano, and "his" jazz group at the inaugural party. (Photo by Fletcher.)

OSMA Submits Three Resolutions

Reference Committees met Monday, June 20; and the House of Delegates took action on their recommendations during sessions on Tuesday, Wednesday, and Thursday, June 21-23. The OSMA submitted three resolutions to the AMA House of Delegates for consideration at this meeting:

(1) Resolution No. 92 asked that the AMA urge the Joint Commission on Accreditation of Hospitals (JCAH) to delete from its standards those specifications that require detailed post-hospitalization instructions. Many physicians testified in support of this resolution, and the Committee introduced a substitute resolution to the House which was adopted. The substitute resolution read as follows:

RESOLVED, That the American Medical Association urge that the Joint Commission on Accreditation of Hospitals review and reconsider those specifications of the detailed discharge summaries in the standards of the JCAH in order to permit a shorter resume including detailed post-hospital instructions.



LEFT TO RIGHT: Richard T. F. Schmidt, M.D., and OSMA Councilor Richard E. Hartle, M.D., at a recent AMA Delegation meeting. (Photo by Jacobson.)

(2) Resolution No. 93 provided for the option of direct billing for Medicaid patients as physicians may do for Medicare patients. The resolution was adopted and was referred to the Board of Trustees for implementation in an effort to achieve this equality.

(3) Resolution No. 94 asked that the AMA reaffirm its policy that physicians must personally supervise interns and residents in order to charge for services rendered. Report H of the Council on Medical Service was written in the same vein. The House adopted both Report H and Resolution 94.

Full-Time AMA President

The Committee on Constitution and Bylaws heard a number of issues of interest to Ohio physicians. The consideration of a full-time AMA president was generously debated in the Committee and likewise on the House floor. The Council on Long-Range Planning and Development recommended that the executive vice-president also be given the title of president and that this individual be selected by the Board of Trustees to be the chief executive officer and spokesman of the AMA. Their recommendation included the gradual year-by-year deletion of the offices of president-elect, president, and past president, with each of these individuals being replaced, on an annual basis, by an additional member to the Board of Trustees.

The need for unification of the AMA spokesman was unquestioned, but the House of Delegates felt that this matter deserved more extensive study. It also felt that the Delegates deserved the right of election or appointment of a full-time president. Therefore, this matter was referred to the Board of Trustees for a report to be given at the Interim Meeting to be held in Chicago in December 1977.

Other matters considered by this committee were basically housekeeping items.

Medical Services Matters

Physician Services Review Organizations

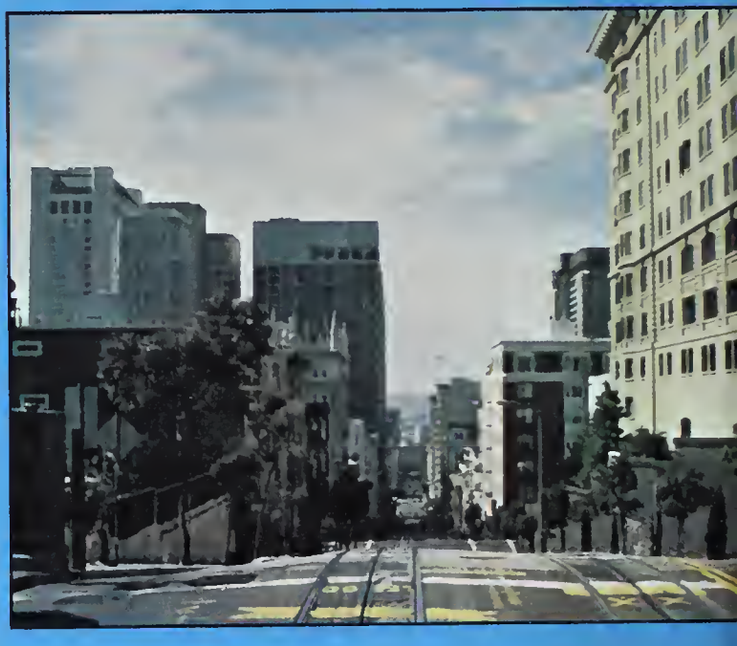
Reference Committee A dealt with medical services matters. Resolution No. 28, encouraging the Department of Health, Education, and Welfare (HEW) to provide funding for statewide physician services review organization (PSRO) support centers when the states request this action, resulted from the efforts by HEW to avoid the creation of such statewide PSROs. The creation of these PSROs had been requested by physicians. The resolution passed.

Resolution No. 46 also dealt with PSROs. It encouraged HEW to demand the same level of competence from nonphysician PSROs as from physician PSROs. The latter are preferred. The resolution requested further that physician reviewers be licensed in the state performing the review and that they be in active practice. The resolution was adopted in substitute form.

(continued on page 533)











AMA Report *(continued)*

Medicare

Report Y of the Board of Trustees explains the AMA's actions regarding proposed regulations governing Medicare reimbursement of renal physicians. On January 10, 1977, the AMA responded to Resolution 83 (C-76) which asked the Association to oppose a proposed regulation relating to the reimbursement of renal physicians for professional services rendered to renal disease patients under the Medicare Program. Part of the AMA's comment to the Social Security Administration stated:

> . . . the AMA believes that there is no compelling reason to invent new or different ways of compensating physicians. The artificial reimbursement formula formally established under this rule would further restrict present Medicare reimbursement, could attempt an unwarranted differentiation of integral aspects of physicians' services, and would discourage increased quality patient care.
>
> The American Medical Association urges the Commissioners to withdraw this proposed regulation and to propose a new one formulated in line with our comments.

The AMA Council on Legislation also considered the pending legislation relating to reimbursement under the End Stage Renal Disease Program. It stated:

> . . . notes and supports the long-standing AMA policy of payment as usual, customary and reasonable charges. The Council believes this reimbursement principle should be supported under Medicare and that a mechanism for payment different from other physicians under Medicare should not be supported.

The Board of Trustees concurred with both of these actions. Report Y was adopted in lieu of Resolution 83 (C-76).

Resolution No. 80 sought elimination of undesirable aspects of the arbitrary assignment of a profile of fees by Medicare to a physician establishing a new practice. The problem has arisen that new practicing physicians are arbitrarily given profiles without the opportunity to generate their own. The House objected to this system and efforts will be made to correct the problem.

The House directed the officers and staff of the AMA to investigate all possible avenues including legislation which might prevent the further release of Medicare-Medicaid reimbursement lists to the press and the public (Resolution No. 101). This action, of course, arose out of the recent problems of the marked inaccuracy of the HEW lists.

Relative Value Scales

Report I of the Board of Trustees covered needed legislation to permit the medical profession to develop and to use relative value studies. The report, which was adopted, made clear the fact that the profession, not HEW, should undertake this task.

Physician Copy of Hospital Bill

The House adopted Resolution No. 18 which asked that the AMA work with the American Hospital Association to provide physicians with a copy of the hospital bill of each of their patients. This effort is designed to make the practicing physician aware of hospital costs so that he not only can have some effect on reducing these costs but also can be knowledgeable as to where the cost problems exist and how he can better inform his patients of the costs.

Second Opinion

Resolution No. 77 concerned mandatory consultation ("second opinion"). The House adopted the resolution which read in part:

> Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the House of Delegates of the American Medical Association (1) reaffirms the right of a patient or a physician to seek consultation freely with any consultant of his/her choice; (2) opposes the concept of mandatory consultation when required by a third party payor; (3) supports the concept that when consultation is required by a third party payor, the consultation should be at no cost to the patient; (4) opposes the concept of closed panels of consultants, and (5) supports the concept that if consultation is required by a third party payor, the patient should be allowed to choose a physician of his/her choice.

Resolutions Requiring Legislation

Reference Committee B considered all resolutions pertaining to legislation. The foremost matter of policy that was passed by the House regarding this committee was to change the terminology of *national health insurance* to *comprehensive health insurance*. The House indicated that this terminology was to be used henceforth in all AMA publications.

Food, Drug, and Cosmetic Act

Report BB of the Board of Trustees reviews the most recent pronouncement of the House of Delegates concerning the 1962 Kefauver-Harris Amendments to the Federal Food, Drug, and Cosmetic Act in the light of pending legislation to repeal those amendments. The report stresses the importance of streamlining the drug approval process while maintaining an end result that all approved drugs be safe and effective. The Board asked the AMA Council on Legislation to initiate an intense review of the Federal Food, Drug, and Cosmetic Act, recommending appropriate action to ensure that safe and effective drugs are made readily available to the American people. The House adopted Report BB and requested that a report be submitted to it at the Interim Meeting in December 1977.

Department of Health Care

Resolution No. 33 asked that the AMA support or sponsor legislation to create a separate, federal-cabinet-level Department of Health Care. It was noted that, in accordance with long-standing Association policy, the Council on Legislation had already developed draft federal legislation to accomplish this cabinet appointment. Under the AMA bill, the new position would be held by a physician. The resolution was adopted.

The House also adopted a resolution (No. 36) that requested AMA opposition to the Maternal and Child

(continued on page 534)

Photos on page 532 by Mulgrew.

AMA Report *(continued)*

Health Care Act (HR 1702) and the National Health Insurance for Mothers and Children Act (S 370). These legislative proposals contain many provisions, including the financing and control provision, which would not be in the best interest of the public or of the medical profession.

Collective Bargaining for Residents

A matter requiring much committee testimony and further discussion on the House floor was whether medical residents employed by non-public institutions are entitled to the rights granted by the National Labor Relations Act (NLRA). These rights include the right, if so chosen, to organize and to bargain collectively. On April 4, 1977, the AMA presented testimony in support of H.R. 2222, a bill recognizing the concept. According to the Committee, the AMA testimony emphasized the view that "the medical resident was both a student and an employee, that this dual role is not mutually exclusive and does not detract from medical education, that as an employee the resident should have the rights generally extended to employees under the NLRA, that irrespective of his role as an employee the resident must utilize mature judgment in exercising his rights 'without sacrificing the quality of graduate medical education or patient care,' and that endorsement of those rights by the AMA 'does not explicitly or by implication carry any support for trade unionism.'"

The Committee recommended continued support of this policy. However, it stressed that the resident must exercise mature judgment. Also, the Committee noted: ". . . any individual organization of residents seeking negotiation as a means of resolving disputes should to the extent possible call upon component and constituent medical societies for assistance in achieving legitimate objectives as recommended in Report U (C-75)." The House adopted the recommendations of the Committee.

Health Planning

The House passed two resolutions dealing with PL 93-641, the National Health Planning and Resources Development Act of 1974. One (Substitute Resolution No. 11) directed the AMA to commend the appropriate congressmen for their introduction of legislation to repeal the Act. The other (Resolution No. 49) supported development of a program assisting physicians and medical societies involved in planning which would monitor and disseminate results of the planning process nationwide.



LEFT TO RIGHT: John W. Moses, M.D., and H. William Porterfield, M.D. (Photo by Jacobson.)

Hospital Cost Containment

The House opposed the Carter Administration's hospital cost containment legislation of 1977 by means of a substitute resolution which reads:

"RESOLVED, That the AMA continue to voice its opposition to HR 6575 and S 1391 as introduced in the 95th Congress."



LEFT TO RIGHT: Oscar W. Clarke, M.D., Vice-Chairman of the Ohio Delegation; P. John Robechek, M.D. Chairman of the Delegation; and Robert G. Thomas, M.D., at the 1977 OSMA Annual Meeting. (Photo by Jacobson.)

Medical Education

Reference Committee C studied all resolutions having to do with medical education, both graduate and postgraduate. The House heard concern expressed for the lack of one year of basic general training following completion of medical school and prior to entering a residency program. Delegates representing many specialties voiced this problem, and the House endorsed efforts to reinstitute this training in specialties other than internal medicine and family practice.

The House adopted a number of reports of the Council on Medical Education on revision of *Essentials of Approved Residencies* pertaining to residencies of several medical specialties: thoracic surgery (Report G); preventive medicine, which includes general preventive medicine, aerospace medicine, occupational medicine, and public health (Report H); general surgery (Report I); urology (Report K); and neurological surgery (Report L).

Also adopted was Report C, by and pertaining to the Council on Medical Education Liaison Committee on Continuing Medical Education (LCCME). It was determined that the LCCME should be composed of repre-

(continued on page 536)

When **impotence** *due to*

androgenic deficiency is driving them apart



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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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sentatives from the AMA (4), Association of American Medical Colleges (3), American Board of Medical Specialities (3), Council of Medical Specialty Societies (3), American Hospital Association (3), Association for Hospital Medical Education (1), Federation of State Medical Boards (1), public (1), and federal government (1). The Report also quotes AMA policy to continue the participation of state medical societies in the accreditation process of the LCCME.

Along the same line, the House adopted Report D of the Council on Medical Education which is a progress report on the participation of medical students in the process of accreditation of educational programs leading to the medical degree.

Resolution No. 26 asked the AMA to affirm that failure of a board-certified practitioner to undergo recertification should not be adequate cause to withhold or modify hospital privileges and that withholding or modifying such privileges should be based on the assessment of performance. The House adopted the resolution.

The House also aproved reciprocity of continuing medical education credits with the Canadian Medical Association and directed that a method of such reciprocity be developed.

Hospitals and Medical Facilities

Physician-Hospital Relationship

Committee D discussed resolutions relating to hospitals and medical facilities. The physician-hospital relationship was covered in Report R of the Board of Trustees, which was adopted. Recommended policy included the following:

(1) Although final authority granting, denial, termination, or limitation of hospital staff privileges is vested in the governing board of the hospital, it is expected that the judgment of the organized medical staff will be relied upon in the evaluation (process) . . .

(2) Physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it.

(3) Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities . . . Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefor.

(4) Hospitals are entitled to recover their reimbursable expenses, determined in accordance with recognized, standard, hospital cost-accounting principles, from the operation of departments in which hospital-associated medical specialists perform personally or supervise or direct the services provided patients.

(5) The form of the contractual or financial arrangement between hospitals and hospital-associated physicians depends upon the facts and practical considerations existing in each situation.

(6) Hospital-associated medical specialists are entitled to charge (1) for the services they provide in accordance with the same standards of equity and fairness that apply to the charges of other physicians; and (2) in supervising personnel under their direction.

(7) There should be no duplication of charges to the patient where services are not actually provided by both the physician and the hospital.

Hospital Privileges for Podiatrists

Report X of the Board of Trustees was presented as the result of a study by the Liaison Committee on Podiatry, conducted during 1976 and 1977. The Report, which was adopted, read in part:

The American Medical Association recognizes the right of qualified limited practitioners, such as podiatrists . . . to seek opportunities to utilize their knowledge and skills in hospitals and other health care facilities. The type of privileges or membership available should be spelled out in the hospital medical staff bylaws in accordance with the applicable state laws and regulations.

Qualified podiatrists appropriately may be granted practice privileges within the scope of their competencies . . . The hospital medical staff should establish a system for evaluating individual applicants that is objective, impartial and fair; that is broad enough to recognize professional excellence and limited enough to safeguard patients. Provisional or probationary privileges are recommended for all hospital appointees for the first year or an appropriate period as provided in the hospital medical staff bylaws . . .

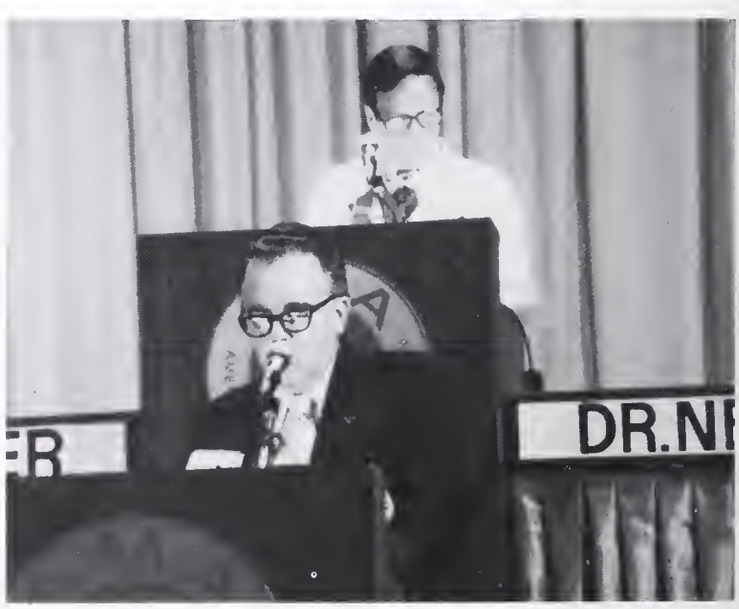
In the final analysis, operating room observation, record review, tissue review and medical care evaluation studies remain the foundation of evaluation for practice privileges for podiatrists, as well as for physicians and other independent practitioners providing professional services in hospitals . . . .

Strikes and Reviews

The House referred Resolution 2 (Strikes in the Health Care System) to the Board of Trustees. The resolution called for the AMA to prepare policies and strategies to deal with strikes, lockouts, job actions, and other work stoppages that affect the quality and availability of medical care. The Board is to report to the House at the 1978 Annual Convention.

The House endorsed the concept that the number of complete on-site reviews of a hospital be reduced to a

(continued on page 538)



Oscar W. Clarke, M.D., nominates W. J. Lewis, M.D., for the position of vice speaker as the current vice speaker, William Y. Rial, M.D., presides. (Photo by Porterfield.)



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AMA Report *(continued)*

minimum and that these reviews be comprehensive enough to supply data to all the legitimate agencies and groups so entitled (Resolution No. 30). This resolution arose as the result of multiple, duplicating reviews being carried out by the Joint Commission on Accreditation of Hospitals and government agencies.

Resolution No. 48, which was adopted by the House, asked that the AMA develop legislation proposals that would require federal hospitals and health maintenance organizations to participate in the same regulatory process as non-federal institutions.

The House also passed a resolution (No. 106) asking that the AMA define and promote for its members an understanding of the legal concept of physicians as independent contractors.

Public Health

Resolution Committee E considered scientific-public health matters. One of these matters was Report N of the Board of Trustees regarding television violence. The Board was commended for its strong stand during the last year and the very favorable response that the public has given to medicine's interest and concern about violence on television.

The House adopted Report Q of the Board which supported community programs to assure adequate education, hypertension screening, and monitoring of blood pressure measurement as part of the national effort to combat hypertension. This report presented an alternative to Resolution 34 (C-76) relating to the role of pharmacists in hypertension screening.

It is recommended that all physicians read Report B of the Judicial Council on the leadership role of the AMA in the field of medical ethics.

The House adopted Resolution No. 3 wherein the AMA opposes mandatory patient package inserts for all drugs approved for marketing by the FDA.



LEFT TO RIGHT: Dr. and Mrs. Budd and their sons Charles F. Budd, M.D., and John H. Budd, Jr. (Photo by Fletcher.)

Saccharin

The saccharin ban was also a major topic of discussion. The House passed a substitute amendment submitted by the New Jersey Delegation. This resolution called for the AMA to . . . "encourage enactment of an amendment to the Food Additive Act to prohibit the use of food additives on the basis of scientifically valid studies demonstrating an increased incidence of carcinogenicity in humans in doses normally consumed by humans or in animals in doses comparable to those normally consumed by humans." The resolution also asked that any foods with additives that have demonstrated any incidence of carcinogenicity in humans or other animals carry a warning on their labels.

Laetrile

Another very hot issue was that of Laetril (amygdalin). Lengthy discussions were held in committee and on the floor of the House. A substitute resolution by the Ohio delegation was adopted which states simply: "That the AMA continue to state to all physicians in the country and the general public the lack of scientific evidence for the use of Laetril in the treatment of cancer."

AMA Operations Issues

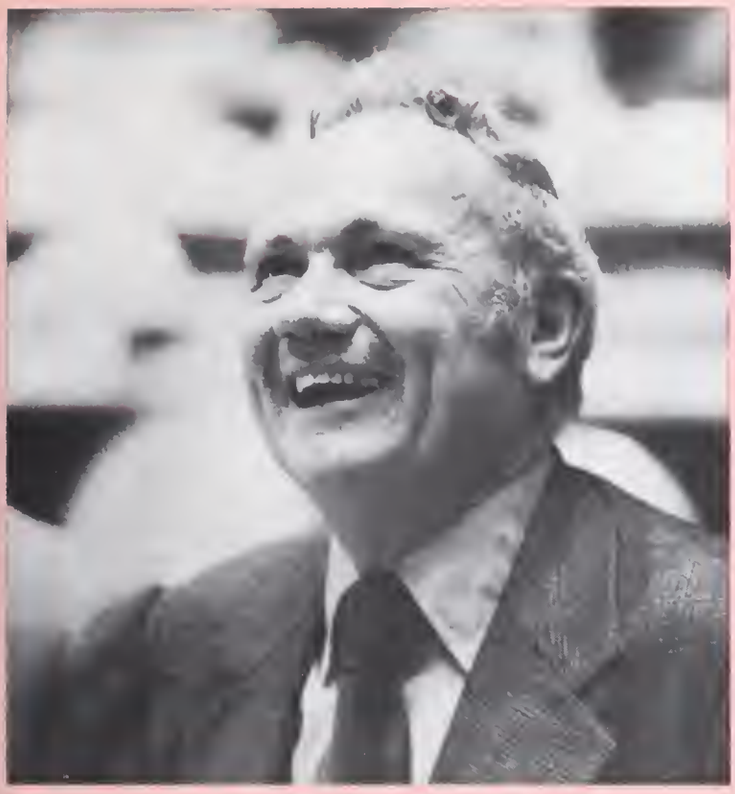
Dues to Remain at $250

Reference Committee F considered matters relating to the Board of Trustees. Report A to the Board, the auditor's report, elicited commendation from the House of Delegates for the AMA Officers, Board, and Staff for their outstanding fiscal leadership. The AMA has come back from a very significant financial crisis of two years ago to show marked fiscal stability at this time.

Report C of the Board recommended that AMA dues continue at the current $250. Report GG of the Board concerned direct billing for AMA membership. This matter was debated at great length and was referred back to the Board of Trustees for further review and recommendation.

Specialty Society Representation

Another matter of considerable controversy was specialty society representation in the AMA House of Delegates. The House adopted the recommendation of the Council on Long Range Planning and Development (Report A) that there be direct specialty society representation in the House. A further portion of this report suggested how this representation was to be achieved. This portion of the report was referred to the Board of Trustees for study as to alternative routes. A report is to be presented at the Interim Meeting in December 1977. The report continued with the recommendation: "That the convention expenses of all direct specialty society delegates be borne by the specialty societies just as the state societies financially support their delegations." The House adopted this recommendation with the deletion of the word *direct*. If adopted, this change will affect



W. J. Lewis, M.D. (Photo by Fletcher.)

the numerical make-up of the House as follows: Direct Specialty Society Delegates— 46 (from current 0); Section Council Delegates— 0 (from current 28); State Society Delegates— 213 (currently 213); Other: Military, Government, Student, Interns and Residents, and Medical Schools— 8 (currently 8). The total number of delegates to be seated in the House would increase from 249 to 267.

Financing a Medical Education

The House also considered Report G of the American Medical Association Education and Research Foundation. Considerable discussion was generated regarding the problems that students are having in securing loans, especially in lieu of the increasing costs of medical education. Therefore, it was determined that there exists a need for reevaluation of the student loan program. The House directed this evaluation to be carried out by AMA-Education and Research Foundation.

Miscellaneous Business

Reference Committees G and H considered miscellaneous business. Included was Resolution No. 9 which was passed to encourage third parties including HEW to use *physician* and *patient* instead of *provider* or *recipient* or *consumer* in any statement or report.

The House also adopted Report K of the Board of Trustees regarding expert medical testimony. It asks that the AMA urge that expert witnesses, including physicians, testify as unbiased witnesses reporting to the court the material to be used by one or both sides as they see fit. Physicians, as medical witnesses, should not allow themselves to become partisans in a trial. In addition, the report endorses the use of panels of impartial medical experts already established in many states.

Further information regarding the 1977 AMA Annual Convention may be obtained by contacting the OSMA Headquarters Office (600 S. High St., Columbus 43215, phone: 614/228-6971) or any member of the Ohio Delegation to the AMA. (A complete list appears in *The Journal*, Vol. 73. No. 7. July 1977, page 491.)



THE OHIO DELEGATION *LEFT TO RIGHT:* **Row One:** Robert N. Smith, M.D.; W. J. Lewis, M.D.; H. William Porterfield, M.D.; Oscar W. Clarke, M.D.; and P. John Robechek, M.D. **Row Two:** Jerry L. Hammon, M.D.; Henry A. Crawford, M.D.; Jack Schreiber, M.D.; and Harry K. Hines, M.D. **Not Shown:** Alternate Delegates John E. Albers, M.D.; George N. Bates, M.D.; Dwight L. Becker, M.D.; Theodore J. Castele, M.D.; Richard L. Fulton, M.D.; John J. Gaughan, M.D.; B. Leslie Huffman, Jr., M.D.; William J. Schrimpf, M.D.; and Robert G. Thomas, M.D. (Photo by Fletcher.)

Voluntary Association Versus Compulsory Government

John H. Budd, M.D., President of the American Medical Association

Inaugural Address Delivered at the AMA Annual Convention, June 22, 1977, San Francisco

As I accept the honor of your Presidency, I see in my mind's eye not only the American Medical Association, great as it is, but the American way of life it represents. For this federation of ours has long been the classic example of private, totally voluntary associations in our country. And in being that, it is a citadel for the survival of voluntary action, as opposed to the expanding power of centralized government, in other words, a chief defender of political pluralism, which means the distribution of civil responsibility. Hence, associations such as this one are important not only for themselves but for society as a whole.

As Alexis de Tocqueville argued almost a century and a half ago, in his *Democracy in America:* "If each citizen did not learn to combine with his fellow citizens for the purpose of defending his freedom, it is clear that tyranny would unavoidably increase."

The federal government's efforts to plan and arrange the socio-economic lives of its people are a threat to more than freedom. They threaten to disarrange life itself. They gradually usurp the citizen's sense of responsibility toward his fellow citizens and his own sense of identity and purpose.

As centralized government expands in power and influence, it infuses people with a depressing sensation of powerlessness, of hopelessness in coping with planners, experts, would-be experts, and powerful government agencies. The result, as described by historian John Lukacs, is "a sickening inward feeling that self-government is becoming more and more meaningless, even though the outward and legal forms of democracy remain." Let me add that a decline in the people's sense of power and the growth of federal power can become a vicious circle unless groups like the AMA resist.

Many zealots who politically are left of center would contend that greater federal authority is the only answer to the strength of what they refer to as "The Establishment," which to them is a nasty word. But what does "The Establishment" really mean? According to the dictionary, it means "the existing power structure in society." Well, what could be more of a power structure than the government? At all levels, federal, state, and local, it spends almost 40 percent of the Gross National Product and accounts for about 18 percent of total civilian employment, or 15 million people.

People's Health Assurance

There are those who want the federal government to have another big slice of the Gross National Product, by means of a National Health Insurance (NHI) program that would be Washington-controlled. The Congressional Budget Office has estimated that an NHI plan financed wholly by taxes could raise federal health spending $168 to $200 billion by fiscal 1982. That prospect does not seem to faze Senator Kennedy, Congressman Corman, and supporters of their NHI bill in labor unions and on Capitol Hill. In pleading the umpteenth time for the bill, Senator Kennedy wrote in *National Observer* last March (1977) that "our present methods of getting and paying for health care are dangerously near collapse." The Senator and his fellow believers routinely blare the foghorn, even though the skies have become steadily clearer.



John H. Budd, M.D. (Photo by H. William Porterfield, M.D.)

Thanks to the present pluralistic system, health services and their availability have strengthened over the last 15 years, according to two scientists of the Robert Wood Johnson Foundation, including David E. Rogers, M.D., its president. Writing in *JAMA (Journal of the American Medical Association),* they observe that the system "does work, and perhaps better than we are sometimes wont to recognize." They note that racial and economic gaps in care have largely closed, and the death rate has fallen in general and in various basic categories. Moreover, some 80 percent of the people under 65 (years of age) are financially protected to some degree, at least by private health insurance.

So the greatest threat of *collapse,* to repeat the Senator's scare word, is not *medical* via the present system of care, but *fiscal* via his proposed system of NHI.

This proposal has been grandstanding so long that it is often taken as a synonym of NHI. Slightly more than half the public identifies NHI with government control or financing or both, according to an American Council of Life Insurance survey. The word *national* in National Health Insurance has tended to strengthen that impression, even in the ranks of medicine. Let me emphasize that what is national needn't be federal, any more than is the National League in baseball, or the National Button

(continued on page 542)

Embark on an Adventure in Medical Education

ACP-MKSAP IV Postgraduate Courses

Beginning this August, the American College of Physicians will sponsor 23 intensive, five-day postgraduate courses based on the College's latest Medical Knowledge Self-Assessment Program, MKSAP IV.

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	15-19	New York, New York	703
	22-26	Birmingham, Alabama	704
	29-Sept. 2	Baltimore, Maryland	705
	29-Sept. 2	Seattle, Washington	706
September	7-11	Ann Arbor, Michigan	707
	7-11	Richmond, Virginia	708
	~~7-11~~	~~San Francisco, California~~ **sold out**	~~709~~
	14-18	Kansas City, Missouri	710
	~~26-30~~	~~Cambridge, Massachusetts~~ **sold out**	~~711~~
	26-30	Los Angeles, California	712
	26-30	Philadelphia, Pennsylvania	713
	26-30	Rochester, Minnesota	714
	26-30	Washington, DC	715
October	1-5	Montauk Point, L.I., NY	716
	3-7	Cincinnati, Ohio	717
	3-7	Denver, Colorado	718
	3-7	Houston, Texas	719
	3-7	Pittsburgh, Pennsylvania	720
	10-14	Chicago, Illinois	721
	17-21	Cleveland, Ohio	722
	17-21	New Orleans, Louisiana	723

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D

Inaugural Address *(continued)*

Society, or the National Society Colonial Dames XVII Century. Our bill would bolster and protect the private focus of care and expand the present system. It would do this by depending mainly on employer-employee contributions, and use tax money to cover only the poor and jobless. That money would come from general revenue rather than the Social Security tax. Under our bill, the additional fiscal cost would be about $5 billion. Compare that with the $168 to $200 billion under a totally tax-financed program. To the extent that political power accrues from taxes, our measure would check any net gain in that.

So think of our proposal not as National Health Insurance, but as the people's health assurance. Describing it thus would be highly appropriate because its basic premises tally with what a plurality of the people want, as shown by a Gallup Poll. We cannot ignore the poll's indication that most Americans want some form of NHI. Nor can we ignore the declaration by HEW Secretary Califano that NHI is "a cornerstone in the President's domestic policy." Califano has backstopped those words by appointing an Advisory Committee on NHI Issues.

To borrow a figure of speech from my favorite sport, the ball the Administration pitches is likely to have a Kennedy-Corman curve. And, believe me, we've got to have a bat, namely, our own fine bill. Angry oratory simply won't stop that darned ball!

Health Care Costs

In addition, we must be aware that the private costs of care, not just the fiscal costs, are bound to be a major issue in the health-insurance showdown. The Johnson Foundation, while lauding improvements in care, added that "costs may prove to be the Achilles' heel of this country's arrangements for health services."



Dr. Budd with Mrs. Albert May, President of the OSMA Auxiliary. (Photo by OSMA Auxiliary.)

That issue throws a double challenge in our direction. On the one hand, we must get behind any rational and realistic means of curbing expenses and eagerly await the recommendations of our own National Commission on the Cost of Medical Care. On the other hand, we must publicly pinpoint the basic relationship between medical cost and the quality, sufficiency, and availability of medical services. We must pinpoint the harm that any federal crackdown on costs could do to those three elements of care. Not that I think the public is greatly aroused about charges.

I think most patients share the sense of values reflected in a letter from a Portland, Oregon resident to *Newsweek* magazine, protesting an article therein. The letter said:

> My house, my car and I have all needed repairs. Mine involved my regular physician and four specialists. Taking into consideration actual time spent on the job, from none of the medics did I get a bill as high as I did from carpenters, concrete men, linoleum layers, furnace repairers, plumbers, electrical repairmen, and, above all, auto mechanics. So far all the repairs to me have held up well, but all the others have gone to pot.

My reason in urging a greater public understanding of medical costs is not so much the people, as the eagerness of government to exaggerate and exploit the issue in the name of the people. Cost control has been made a precondition for the Administration's NHI proposal. And it's an underlying objective in the Federal Trade Commission's harassment of our AMA federation and our profession.

In contesting us on such matters as medical advertising and medical-school accreditation, the FTC regards our profession as a trade. It overlooks the distinction drawn by so esteemed a federal figure as the late Supreme Court Justice Louis D. Brandeis, who said:

> A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning, as distinguished from mere skill. It is an occupation which is pursued largely for others and not merely for one's self. It is an occupation in which the amount of financial return is not the accepted measure of success.

The Public's Concept of Medicine Arises From the Individual Physician

Certainly the vast majority of physicians are recognized for their service to others rather than their income. Yet, if we physicians are to conform fully to Justice Brandeis' definition of a profession, we must think of altruistic service in all of its spectrum. We must think of patients in all of their needs, including their needs just as human beings.

Various studies show the public is increasingly disturbed by a lack of personal attention from doctors, long waits in their reception rooms, and an aloof attitude on the part of office staffs. These signs of indifference are not only more irksome to the patient than are medical costs, but they can arouse ill-founded suspicion about those costs.

No matter how hard the AMA strives to speak and

act for all of medicine, the patient's concept of our profession starts with his own physician, and the national concept of physicians is that personalized concept multiplied. However, the Gallup Poll shows that doctor's organizations, such as the AMA, enjoy the confidence of 71 percent of the people, exceeding other categories involved in health policy, especially federal health officials, 49 percent, and labor unions, 47 percent.

The AMA justifies the public confidence in many public-spirited ways, such as our role in planning and staffing rural care, our cosponsorship of a program to coordinate and upgrade inner-city care, our cooperation with six state medical societies in a project aimed at setting national standards for jailhouse care, our campaign against television violence, and, of course, our NHI bill. We justify the public confidence by our relevance to human needs, while the federal bureaucracy, as it gains in power, has tended to become more irrelevant to those needs, a world unto itself.

Nevertheless, to the extent that any patients feel dehumanized by their own doctors, the AMA may appear that much less an association of professionals and that much more an association of tradesmen, much to the delight of the FTC and our other assailants.

A Strong Voice for Medicine

Let me hark back once more to the Brandeis distinction that a profession acts largely for others. To do our best for the public and for medicine itself, we as physicians must act constructively and effectively for each other, through the AMA. To be the means of such action, the AMA must have optimum numerical strength. At the end of 1976, we had 172,000 dues-paying members. But there are some 150,000 physicians who are not members of our federation at any level—national, state, or local. Where are they? And how can we get them to join?

As President, I will be going to many places and making an outsider's appeal for membership. But a more intensive appeal from community insiders, such as you Delegates, is sorely needed. I can come from around corners, but it takes you to cut them. You, and your respective societies, can directly communicate with nonmembers in the hospital, the medical college, the research center, and wherever. Hundreds of the component societies deny membership to doctors who are housestaff, academics, unlicensed industrial employees, and so forth. But, to be a counterweight to federal intervention, we must have the collective weight of our profession. If the AMA is to help preserve the American tradition of private, voluntary associations, all types of physicians must be associated with it.

Members of this House of Delegates: I urge each of you to take formal and informal action in behalf of greater membership. Let our federation, which is the House of Medicine, be filled. For increasingly as dangers ride herd against us, this home is our castle.

comments

John H. Budd, M.D.

In every job there are bright spots, and one of the brightest in mine is the opportunity to know John H. Budd, M.D. Currently President of the American Medical Association, Dr. Budd is a believer in the advancement of the health care profession. He has spent his life improving health care in both the office and the political arena of medicine.

Since his early days in medicine, Dr. Budd has given untold time and energy to the profession he both practices and preaches. Until his year as AMA President-Elect, he carried on a solo family practice in Cleveland— a practice that spanned 39 years.

In addition to his clinical work, he has been active in many medical organizations and activities. Prior to becoming AMA President-Elect, Dr. Budd served on the AMA Board of Trustees for six years and was secretary-treasurer of the AMA and secretary of the board. He also was an AMA commissioner on the Joint Commission on Accreditation of Hospitals and chairman of the Commission's Standards and Survey Procedures Committee. A much longer list of AMA positions would include serving as delegate from Ohio for ten years, eight years as chairman of the delegation.

Locally, Dr. Budd served on many OSMA committees and as president of the Academy of Medicine of Cleveland. He is a founding member and former president of the Board of Medical and Surgical Consultants of the Cleveland Safety Department and a trustee of Blue Cross of Northeast Ohio. He has also been extremely active in community affairs.

His efforts on behalf of the medical profession have been honored again and again: the OSMA presented him the Distinguished Service Citation (1974), the Selective Service System gave a Citation for 25 years Uncompensated Service (1973), a Special Citation came from the Deaconess Hospital (Cleveland) Board of Trustees (1974), and the Academy of Medicine of Cleveland awarded the Honors of the Academy (1967), Distinguished Membership (1973), and a Special Award (1974).

Medicine, however, is not the only dimension to John H. Budd's life. Dr. Budd has been supported throughout his career by his wife Irma and his sons, Attorney John H. Budd, Jr., and Charles F. Budd, M.D., an orthopedic surgeon. He is also an exceptional musician whose skill at the piano is renowned. In fact, at one point in his life, Dr. Budd considered seriously a career in music. Added to these interests is his appreciation of baseball and hockey as a fan.

Dr. Budd's inauguration as President of the American Medical Association not only will benefit the medical profession, but also is a great tribute to a man whose life has been dedicated to medicine. Ohio salutes him. And I, if I may be allowed a personal reflection, am truly lucky to know him. L.A.J.

comments

Robert M. Zollinger, M.D.

Recipient of the Dr. Rodman E. Sheen and Thomas G. Sheen Award in recognition of his international medical leadership as a surgeon, a foremost teacher in graduate surgical education, and a renowned researcher in gastrointestinal physiology, pancreatic pathology and endocrinology.

(Quoted from the Sheen Award Presented June 19, 1977.)

A true Ohioan born and raised in Millersport, Fairfield County, Dr. Zollinger's father, grandfather, and great-grandfather were all farmers in this Ohio rural community. The Zollinger family can be traced to Germany and Switzerland, and six members were Pennsylvania farmer-patriot soldiers in the American Revolutionary War.

While a student at The Ohio State University, where he received both his bachelors and medical degrees, he met a Cincinnati coed, Louise Kiewit, and they were married in 1929. This union was blessed by first a son and then a daughter. Robert, the son, is now a professor of surgery at Case Western Reserve University School of Medicine and has coauthored with his father the *Atlas of Surgical Operations*. Myra Lou, is the wife of a professor of economics at Duke University, Durham, North Carolina.

Louise and Robert Zollinger have many mutual avocations and hobbies as well as a devotion to family and church. They are collectors and authorities on Irish Belleek china and sea shells. They are competitive cultivators of roses, gourds, melons, and garden vegetables. Both are nationally accredited rose judges. As a youth in the 4-H Club, Dr. Zollinger was an Ohio State Fair "sweepstakes" winner for the best "short horn bull" of the year.

As a civic leader, he has served as member and chairman of the Metropolitan Park Board of Franklin County. Nationally, he has provided leadership in the American Horticulture Society for the development of a national horticulture park near Mt. Vernon, Virginia.



Robert M. Zollinger, M.D., accepts the applause of the OSMA House of Delegates. (Photo by Jacobson.)



LEFT TO RIGHT: Richard L. Meiling, M.D., escorts Dr. Zollinger to the podium at the 1977 OSMA House of Delegates. (Photo by Linda A. Jacobson.)

Dr. Zollinger volunteered in 1941 for duty as a medical corps officer in the U.S. Army. He served from 1942 to 1945 in the European Theater of Operations, rising in rank to colonel and commanding the Fifth General Hospital. He has served continuously since World War II as a civilian surgical consultant to the Surgeon General, U.S. Army, and to the U.S. Veterans Administration.

Foreign nations, national and international surgical societies, and many universities have honored him as a master surgeon, surgical researcher, clinician, medical educator, author, and humanitarian.*

The Ohio State University established the Robert M. Zollinger Chair in Surgery in his honor in 1964. His former residents and associates established the Robert M. Zollinger (Surgical) Club in 1955, which presents a surgical scientific program annually in honor of their teacher, friend, and colleague.

Whether it be on grand rounds, as visiting professor or monitor of a seminar, or as editor of a journal, his sharp repartee and his uncanny ability to penetrate by the most direct route to the crux of the problem are renowned.

As Ohio State University Professor Emeritus in Surgery since 1974, he can still be found almost daily in the operating room, making rounds with young colleagues, attending patients, or giving lectures. He calls this retirement.

The Ohio State Medical Association is honored to recognize one of its members, Robert Milton Zollinger, M.D., recipient of the AMA Sheen Award as the Outstanding Physician of 1977, a master surgeon, an educator, a humanitarian, an outstanding citizen, and a gentleman. R.L.M.

*The OSMA gave Dr. Zollinger its Distinguished Service Award in 1976.

My First Article

Robert M. Zollinger, M.D.

IT HARDLY SEEMS POSSIBLE that almost 50 years have elapsed since my name first appeared as one of the coauthors of an article in a medical publication. The title of the paper was "A Histological Study of Tumors of the Central Nervous System," published in the April 1929 issue of *The Ohio State Medical Journal*.[1] However, the material for the article was developed in the fall of 1927. Early mention should be made of the fact that my name was last, but it was proudly preceded by that of the most distinguished Dr. Elliott Carr Cutler, Chairman of the Department of Surgery of the Western Reserve University, and the equally distinguished Dr. Alan R. Moritz, Chief Pathologist of the Lakeside Hospital in Cleveland.

It was unusually fortunate that my internship at Peter Bent Brigham Hospital in Boston didn't begin until January 1, 1928, which provided six months of "what to do" following graduation from The Ohio State Univeristy College of Medicine. Dr. Harvey Cushing suggested that one of his favorite pupils, Dr. Elliott Cutler, who had succeeded the internationally famous Dr. George Crile as head of the Department of Surgery at Western Reserve University and as chief surgeon of the Lakeside Hospital, might find a place for me as a voluntary assistant in his laboratory. This was arranged following an interview with Dr. Cutler in 1927. It always seemed to me that this six months was the most baffling period I had ever experienced until 3½ years of overseas duty in World War II came along. As the years rolled by, this six-month interval in 1927 played a much larger role in opportunities to come than had ever been anticipated.

Laboratory Experience

Upon reporting to the old laboratory on Ninth Street in Cleveland, there was some delay in developing responsible plans to keep the recent graduate busy and interested. The house staff apparently had not had contact with a medical graduate from "Ohio State" before. In a teasing fashion, they inquired if I had taken "culture or agriculture down at that big State School in Columbus." I soon developed a standard reply: "Quiz me, you so-and-so, and find out." This chip-on-the-shoulder attitude served as a great stimulus to study hard and to uphold the honor of my alma mater, as well as to bolster my personal pride.

My assignment to the medical gastrointestinal clinic during this six months resulted in a life-long interest in the problems associated with this system. In addition, weekly attendance in the orthopedic outpatient department proved most exciting. The resident surgeon was Dr. Rene Fontaine, an associate of Professor Rene Leriche of Paris. Subsequently and for many years, Dr. Fontaine headed a very productive surgical service at the University of Strasbourg, France. However, the primary assignment by the chief was very specific. Records on all of the brain tumors treated on the surgical service during the previous three years, which included his tenure as Professor of Surgery, as well as those specimens obtained by autopsy on the surgical service, were to be restudied and the tumors classified. It was not hard to conceive that such a study by a recent medical school graduate would not be productive. The authoritative book, *Tumors of the Glioma Group On a Histogenetic Basis,* by Bailey and Cushing, had been published the previous year (1926).[2] Fortunately, it included many beautiful photomicrographs which made a diagnosis by comparison with the figures in the book relatively reliable.

Dr. Cutler was very definite that a novice should participate in everything concerned with a project from the very beginning. This included sharpening the knives of the microtome, cutting, staining, and photographing the slides. To ensure as wide a distribution of the various types of tumors as possible, all specimens were to be studied. Dr. Alan Moritz showed great empathy and patience as he provided frequent guidance and moral support. A recent review of my article served to recall the pride which slowly followed the proper staining of an especially "good" section. Once during the

Dr. Zollinger, Columbus, Emeritus Professor and Chairman, Department of Surgery, The Ohio State University College of Medicine; and 1977 recipient of the Dr. Rodman E. Sheen and Thomas G. Sheen Award bestowed by the AMA for scientific achievement.

Submitted May 9, 1977.

study, the Professor called and asked if I had read the article by Penfield in "S. G. & O."[3] I had not read the article because I didn't have the slightest idea of the meaning of "S. G. & O"! It took some effort to find the article by Dr. Wilder Penfield which had been published in the journal, *Surgery, Gynecology and Obstetrics,* in the fall of 1927. (Hopefully, modern libraries and reading assignments have made today's medical students more familiar with medical journals on all clinic subjects.)

As the end of the six-month period approached, the microscopic slides were photographed and lantern slides were developed. It was frightening to me to learn that this material was to be used in one of the ten-minute presentations before a section of the Academy of Medicine in the medical school. My apprehension about this first speaking assignment seemed to mount as the day approached until my talk was completely memorized and could be presented in a rapid-fire, confident-but-nervous manner!

A well-known senior professor of anatomy was heard to say: "Gentlemen, we have just heard a pathological marathon!"

The material was presented to Dr. Cutler. In due time, I received his letter stating that he and Dr. Moritz had reworked the material and, if there were no objections, he would present it before the 82nd Annual Meeting of the Ohio State Medical Association to be held in Cincinnati in May 1928. The paper was published about one year later.[1]

Internship and Residency

As a result of the experiences in the laboratory and efforts at writing "my first paper," another short assignment to the laboratory during my surgical internship at the Peter Bent Brigham Hospital was a rewarding experience. Working under the direction of the pioneer venous authority, Dr. John Homans, an experimental method for the development of lymphedema in the extremity of the dog was developed and published. The laboratory time was part of a three-month interlude which included time in anesthesiology. Perhaps it was developed as a test period to determine which members of the house staff had a potential for surgical research.

Some good points of the system included the staggering of the internship, with two unmarried, surgical interns, or "pups," starting every three months. This system avoided the current method of everyone starting at the same level and holding the same status quo throughout the year; in contrast, the staggered system provided progressive responsibility. After the initial three months, the intern was relatively free of routine laboratory work This certainly played a major role in sustaining a high morale among the house officers.

During his first three months, the "pup" rarely had any time off — day or night; he might average two dozen white blood cell counts and urine examinations a day. In addition, he was responsible for catherizations, the insertion of clysis needles, gastric lavage, typing and cross-matching blood, and other duties. A great deal of time was spent in the late evening preparing intravenous injections of gallbladder dye. While on the urology service, the intravenous "uroselectan" had to be administered early in the morning in order to show the results to the chief of urology before starting the morning schedule. The subsequent absence of pyogenic reactions and the transfer of the majority of visualization procedures to other departments certainly has freed the house staff of many responsibilities and saved a great deal of valuable time.

In addition, the beginning intern, the "pup," served as instrument man, a system I continue to believe has great merit. He selected instruments for the operation to which he was assigned the following day. Many times there was great competition to get the best instruments in order to please a particular chief. It was the intern's responsibility to sterilize the instruments, set them out on the table, and hand them to the surgeon upon request. On Dr. Cushing's service, it took at least an hour in the morning before the surgery to make such preparation. In addition, the "instrument man" had only a few moments, while the chief donned gloves and gown, to place a few essential instruments on a sterile platform next to the site of operation. This was to be done silently since the patient often was under local anesthesia and distinguished visitors were nearby in the stands. The latter, incidentally, were in street clothes with a loose fitting gown and nothing more than a long gauze bandage wrapped about the head to partially cover the nose and mouth.

It took approximately three weeks, six days a week, serving as "instrument man" in neurosurgery until the great day arrived when the "pup" could say he automatically supplied the chief with every instrument without the latter making a single request. This rigid discipline in the operating room, so neglected today, made up in part for the lack of operating experience and also ensured that the years of technique developed by the master would be followed automatically. A Spartan discipline regulated all procedures and demanded a daily effort not unlike training for the Olympic games!

It also is interesting to recall that the surgical interns were in complete control of their ward patients during the last three to four months of the 1½-year internship. Under the closest supervision of the chief resident and, in turn, the senior staff member on assignment, the two general surgical residents were in charge of the private patients and assisted in operations on them. However, the surgical intern was always the first assistant on the cases from his ward, and on occasion, was the operating surgeon.

Two years later, after having two articles published and performing approximately 15 operations that perhaps could be called major, I began my assistant residency at Lakeside Hospital in Cleveland in July 1929. My previous experience in the orthopedic outpatient clinic made the return to this service one that was truly anticipated. A surgical intern also was assigned to the service;

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there were no specialty residents except in gynecology. During this era, the general surgical resident was assured a fine experience in the several surgical specialty fields, which served as an excellent background in the development of a general surgeon. Within a few years, the dramatic advances in thoracic and cardiovascular surgery siphoned the residents away from the specialty rotations. This was especially true after World War II. In turn, the surgical specialties greatly increased their own resident staff, and soon there was no room for the resident in general surgery.

The individual in training who has had a period of time set aside to think and to carry on some type of research, learns principles which will be of inestimable value in the future. It is consistent with the current trends that all physicians manifest evidence of self-education and personal updating of the most modern forms of therapy and technique. This current trend will require familiarity with current literature which, in turn, will place greater demands on the capabilities of those who write, lecture, and work to develop new concepts both clinically and in the laboratory.

The Importance of Recording Research Studies

Some have said too many articles have been written. This may be true, but few recent graduates are aware of what was written only a short time ago. Not only must new principles and techniques be reported, but old principles need to be reemphasized for the benefit of the increasing number of graduates from medical schools in both the United States and foreign countries. It should be remembered that churches recite their principles regarding sin every seven days. Over the years, we have "jokingly" implied that those who write stay better informed since they read the literature to see if subsequent authors referred to their efforts. Furthermore, the author should know far more about the subject than a great majority of his readers.

The development of this "first article" in 1927 apparently assured an appointment as Assistant Resident in Surgery at Lakeside Hospital two years later, following the completion of my surgical internship at the Peter Bent Brigham Hospital. It was apparent two years later that Dr. Cutler fervently hoped to succeed his old chief, Dr. Harvey Cushing, as the Mosely Professor of Surgery at Harvard as well as Chief of Surgery of Peter Bent Brigham Hospital. Since the Brigham Hospital was so heavily committed to the surgery of brain tumors, it is interesting to recall one of the Chief's methods of "tooling up" for this prestigious appointment which he attained three years later in September 1932. As his chief resident surgeon for two years at the Brigham Hospital (1932-1934), I realized we both had good reason to appreciate what had been learned in the paper published three years previously in *The Ohio State Medical Journal.*

This "first article" stimulated an appetite for recording unusual clinical and laboratory observations, but it takes much time and persistence to prepare a medical paper. This was emphasized by Dr. Cutler in his first annual report of the Surgeon-in-Chief of the Peter Bent Brigham Hospital in 1932. He stated: "One might note at this time that one of the characteristics that often sets apart a junior member of the staff from his colleagues in a striking fashion is his actual ability to finish and report a piece of work. Teachers who have this matter deeply at heart know how great is the ordeal for the young man to write his first or even his first dozen papers. He realizes the discriminating ability necessary for looking over and assembling the work, in becoming familiar with the literature, and finally in setting it down on paper. It is common to find eager young men who have good ideas, who are industrious, who will look things up in books, but it is an exceptional man who seems to have the last little push that allows him to get it down on a piece of paper in order to get it into press."

Current authors even of "record-room potboilers" may well be invited to attend a meeting several thousand miles away as the guest of the department or hospital. This fringe benefit hardly existed in the "good old days." However, I have always felt that "my first article" played a significant role in opening up subsequent opportunities for me.

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1977 AMA Auxiliary Convention Highlights

Ingrid May, OSMA Auxiliary President

The 54th Annual Convention of the AMA Auxiliary proved to be as unique as its setting, San Francisco— everyone's favorite convention city! Ohio answered the roll call (as the 42nd state auxiliary to be organized— May 15, 1940) with 17 delegates; 3 alternates; and 2 national board members, Mrs. Malachi Sloan, Montgomery County, and Mrs. Paul Sauvageot, Summit County, in attendance.

It was a proud moment for all Auxilians when Mrs. Norman Gardner, AMA Auxiliary President, presented AMA President Richard Palmer, M.D., a check in the amount of $1,517,612.18 during the opening session of the AMA House of Delegates. Ohio played an important role in raising these American Medical Association Education and Research Foundation (AMA-ERF) funds. We received a Merit Award for our outstanding service and support of the Foundation.

Our contribution of $65,846.29 assured us the No. 1 place in the North Central Region and the No. 2 spot in the nation. The North Central Region, comprised of 12 states, contributed $478,745.55— the largest amount of all four regions. Ohio was also recognized for the largest increase in this year's giving.

Ohio Auxilians are concerned about the future of our medical schools, and this concern was made visible by our hard work to raise AMA-ERF funds. Although California raced us to the No. 1 place this year, Ohio presented the ERF chairman of that state a red carnation as a challenge for 1978. Ohio intends to be No. 1. OSMA members, may we count on your support?

Our delegates returned home with another award: a Membership Award for organizing a new auxiliary in Wood County. Our grand total now stands at 52 organized county auxiliaries. We would like to add many more to that number. An encouraging word from you to your spouses may just help us realize this dream.

A number of educational sessions were presented for Auxiliary members. Three special-interest seminars, cosponsored by the Auxiliary and the AMA Council on Continuing Physician Education, dealt with various aspects of plastic surgery, procedures involved in closing a medical practice, and a hard look at television's tight hold on Americans. During the State Idea Exchange, Mrs. William Myers, OSMA Immediate Past President, shared Ohio's success story of the "ERF Traveling Boutique."

Another valuable session was the Communication Workshop "Bridging the Gap." Good rapport between the auxiliary and its medical society is essential. The society's support, combined with auxiliary cooperation and enthusiasm, can increase the effectiveness of both organizations.

Ohio Auxilians were moved deeply during the installation of a fine, honest Ohio physician, John H. Budd, M.D., as AMA President. I have attended several previous inaugurations, but this year's was certainly very special.

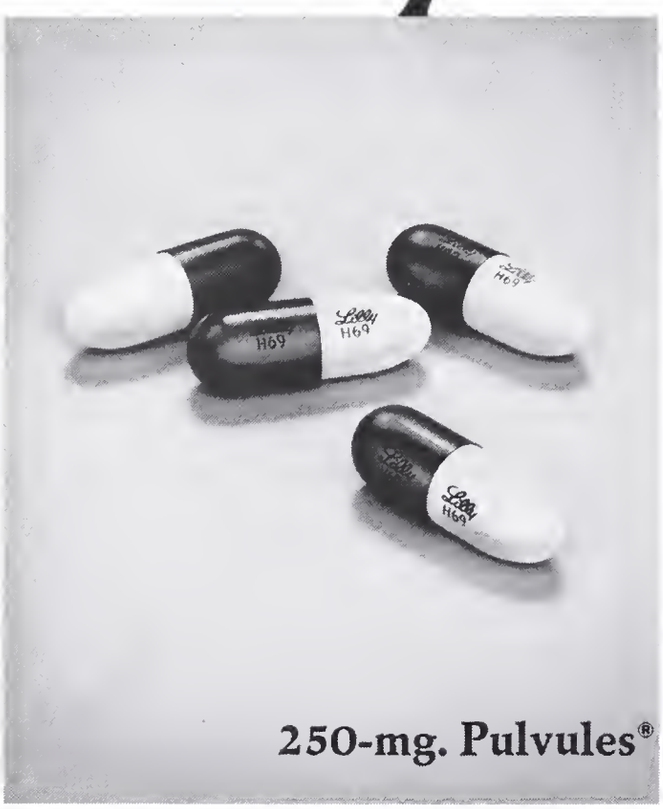
We were also especially thrilled to attend the installation of Auxiliary officers because Ohio's own Eileen Loria (Mrs. Louis Loria, Trumbull County) was installed as a national director and very able Joy Myers (Mrs. William Myers, Pickaway County) began her term as one of two project bank area counselors for the North Central Region. Mrs. Chester Young, newly installed AMA Auxiliary President, urged us "to involve ourselves in things we believe in, to become more visible to the public, to acquire vision for community needs, to communicate with other health oriented organizations, to plan concrete legislative action programs."

In all, this was a most memorable convention!

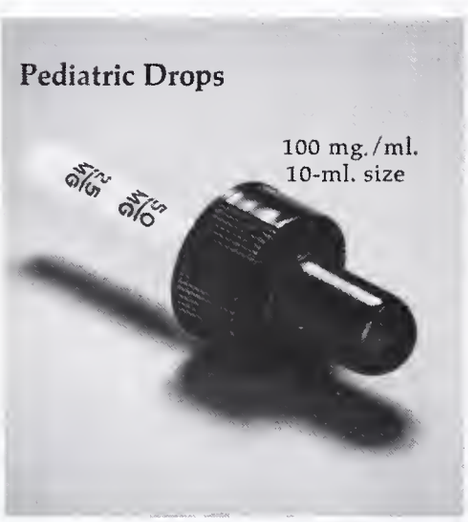


LEFT TO RIGHT: **Row One—** Mrs. L. Loria, Mrs. R. Wiessinger, Mrs. Wm. Myers, Mrs. S. Sato, and Mrs. E. Kieger II. **Row Two—** Mrs. V. LaMaida, Mrs. P. Chrenka, Mrs. W. Mast, Mrs. A. May, Mrs. J. Kaplan, Mrs. R. Perchan, and Mrs. J. Wychgel. **Row Three—** Mrs. J. Hammon, Mrs. J. Tomashefski, Mrs. E. Barrows, Mrs. A. Naji, Mrs. K. Harshman, and Mrs. M. Sloan. **Not Shown—** Mrs. G. Bates, Mrs. H. Crawford, Mrs. J. Liambeis, and Mrs. P. Sauvageot.

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The Pattern of Gram-Negative-Rod Bacteremia in a Community Hospital

Thomas M. File, Jr., M.D.
Donald J. Vincent, M.D.

During the 12-month period ending December 1974 seventy-five patients at a community hospital (Riverside Methodist Hospital, Columbus, Ohio) had gram-negative-rod bacteremia. The incidence of 0.24 percent over the period is low, compared to the findings of studies from university centers. The majority of cases were associated with nonhospital-associated infections. The urinary tract and the gastrointestinal-biliary tract were the most commonly identified sources of bacteremia. Escherichia coli, Proteus, and Klebsiella were the most frequently isolated organisms in urinary-tract-associated bacteremias, whereas E. coli and Bacteroides were most frequently found in the bacteremias associated with the gastrointestinal-biliary tract. On the basis of in vitro sensitivities, all organisms isolated from the blood in those patients with bacteremia suspected to have originated from the urinary tract were susceptible to gentamicin. All organisms isolated from the blood of gastrointestinal-biliary-tract-related bacteremias were susceptible to either clindamycin or gentamicin.

INFECTIONS CAUSED BY gram-negative-rod bacteria are currently recognized as the major source of nosocomial infections and have become a major cause of morbidity and mortality within hospitals across the country. In fact, gram-negative-rod bacteremia may be the direct cause of 132,000 deaths per year, based on current studies.[1,2]

There are many reports in the literature concerning bacteriology, host factors, and therapy of these infections.[1-6] The majority of these reports come from university teaching centers. Patients from such institutions may represent unusually complex medical problems or may be referrals from smaller community hospitals. Thus, the results of these previous reports may reflect a bias. Indeed, a recent editorial from a leading medical journal states: "Since these types of hospitals have substantially higher rates of such infections than community hospitals, national extrapolations from such published reports result in overestimates."[7] This study was undertaken in an effort to define the pattern and incidence of gram-negative-rod bacteremia in our community hospital.

Methods

Patients studied in this report were seen at Riverside Methodist Hospital (RMH) in Columbus, Ohio. RMH is a large, general, community hospital with approximately 800 beds. The hospital is mostly a primary care facility and for purposes of analysis, might be considered as an intermediate between a small community hospital and a large university center.

A retrospective analysis of the available hospital charts was made of the patients reported to have one or more positive blood cultures for gram-negative-rod bacteria during 1974. Sensitivity testing was performed using the standard Bauer-Kirby method.

Results

During the 12-month period ending December 1974, seventy-five patients were found to have gram-negative-rod bacteremia (henceforth referred to as gram-negative bacteremia). There were 31,119 patients admitted to the hospital over this time period. Based on these figures, the incidence of gram-negative bacteremia was 0.24 percent. However, 35 of the 75 patients reported with positive cul-

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Submitted November 18, 1976.

tures were reported after October 1st. Therefore, 44 percent were reported over the last three months. Based on the last three months of study, the incidence climbs to 0.45 percent. It is somewhat difficult to explain this increase in frequency. However, it did correlate with an increase in the number of blood cultures ordered over this time period.

Of the 75 patients reported with positive cultures, it was possible to evaluate the records of 70.

The cases of bacteremia were classified as to hospital-associated and nonhospital-associated. For purposes of analysis, cases of bacteremia that occurred after the fifth day of hospitalization were considered hospital-associated. Using this definition, 31 patients had hospital-associated bacteremia, while 39 had nonhospital-associated bacteremia. The mortality rate of this infection at RMH is shown in Table 1. Forty-five percent of the hospital-associated, gram-negative bacteremia patients died as a direct result of the bacteremia, while only 20 percent of the nonhospital-associated bacteremia patients died. The total mortality rate over this period of time was 31 percent.

Table 2 depicts the frequency with which various bacteria were isolated. There was a total of 73 isolates from 70 patients — some representing polymicrobial bacteremias. On nine occasions, a *Bacteroides species* was isolated. At the time of this study, our bacteriology laboratory did not identify these organisms as to species. However, from the nature of the infection in these cases, it is assumed that most of these were *B. fragilis.*

The association of various underlying diseases or predisposing conditions in patients with gram-negative bacteremia is shown in Table 3.

Two easily obtainable clinical parameters were analyzed: the extent of temperature and the leukocyte response. Temperature elevation at the time of the blood cultures is correlated with mortality in Table 4. This includes data of 61 patients from whose charts a temperature reading was recorded within several hours of obtaining the blood culture. Fifty-seven had a temperature greater than 37.2 C (99 F). Only four patients were afebrile, less than 37.2 (99 F) and greater than 35.5 C (96 F), and all of them died. One was an elderly woman with long-term, congestive heart failure and a rectal abscess who presented with lethargy. Her cultures grew *E. coli.* Another was a 64-year-old man who became

TABLE 1. Mortality* Rate for Patients with Gram-Negative Bacteremia at Riverside Methodist Hospital, Columbus, Ohio

	All Patients Reviewed	Hospital Associated	Nonhospital Associated
Survivors	48	17	31
Deaths	22 (31%)	14	8
Total	70	31	39

* Only deaths directly attributable to bacteremia were considered related deaths. Patients who recovered from bacteremia but died later of unrelated causes were considered as surviving the bacteremia.

TABLE 2. Etiologic Agents in Cases of Gram-Negative Bacteremia at Riverside Methodist Hospital, Columbus, Ohio

	Total Isolates No.	Total Isolates %	Number of Deaths	Mortality Each Species %
E. coli	27	37	5	18
Proteus	16	22	3	19
Mirabilis 15				
Morgani 1				
Klebsiella*	9	12	4	44
Bacteroides†	9	12	3	33
Pseudomonas‡	6	8	5	83
Enterobacter§	1	1	0	0
Serratia‖	3	4	1	
H. influenza	1	1	0	0
Pasteurella¶	1	1	1	

**K. pneumoniae*

†Isolates of Bacteriodes not further identified as to species at time of this study. It is assumed most were *B. fragilis.* (See text.)

‡*P. aeruginosa*

§*E. aerogenes*

‖*S. marcescens* 1; *S. liquefaciens* 2

¶*P. multocida*

TABLE 3. Patients with Gram-Negative Bacteremia with Specific Associated Diseases or Predisposing Conditions

Underlying Disease or Condition	Number
Urinary tract disorder (prostatitis, recurrent urinary-tract infection, or presence of Foley catheter)	15
Carcinoma	14
Hematologic malignancy (including aplastic anemia)	13
Diabetes	11
Receiving immunosuppressant drugs	9
Following surgical manipulation (cystoscopy, gastrointestinal surgery and other procedures)	8
Received antibiotics prior to admission	6
Cerebrovascular accident	5

TABLE 4. Temperature Correlated with Mortality of Patients with Gram-Negative Bacteremia (61 Patients)

Temperature*	Total	Survived	Died	Mortality %
Greater than 38.8C (102F)	49	33	16	33
37.2C to 38.9C (99F to 102F)	8	6	2	25
Less than 37.2C (99F) and greater than 35.5C (96F)	4	0	4	100

*At time of blood culture. Based on oral determinations or equivalent.

Table 5. Leukocyte Response Correlated with Mortality of Patients with Gram-Negative Bacteremia (58 Patients)

White Blood Cell Count cc/mm*	No. of Patients	Survived	Died	Mortality %
>20,000	12	6	6	50
10,000 to 20,000	31	24	7	23
5,000 to 10,000	5	2	3	60
< 5,000	10	2	8	80

*Determined within 12 hours of positive blood culture

Table 6. Frequency of Primary Sites of Infection Associated with Gram-Negative Bacteremia

Infection		Number	Bacteria Isolated	
Urinary tract		35	*E. coli*	17
(Urinary tract infection, Foley catheter, and transurethral resection)			Proteus	9
			Klebsiella	7
			Pseudomonas	2
Gastrointestinal-biliary tract		13*	Bacteroides	6
Rectal abscess	4		*E. coli*	5
Perforated colon	3		Klebsiella	3
Abdominal trauma	1		Proteus	1
Gallbladder disease	4			
Postoperative multiple abscess	1			
Pulmonary (pneumonia)		4	Serratia	
			Pasturella	
			H. influenza	
		4	Pseudomonas	
Female genitalia		2	Bacteroides	
(Septic abscess - infected IUD)			Proteus	
Skin		1	Pseudomonas	
Other		15		

*Two polymicrobial bacteremias:
Postoperative abdominal abscesses (*E. coli* and Bacteroides) 1
Cholecystitis: (Klebsiella and Bacteroides) 1

hypotensive without obvious cardiac or fluid-volume abnormalities on the evening following cystoscopy. This patient grew Klebsiella in his blood cultures. The third patient, a 65-year-old male, developed multiple intra-abdominal abscesses following cholecystectomy and had Bacteroides and *E. coli* bacteremia. The fourth patient was an elderly man who had a *Serratia marcescens* pneumonitis and bacteremia associated with oat cell carcinoma of the lung. No patient in this study was hypothermic, less than 35.5 C (96 F), at the time of the blood cultures. Fifty-eight of the patients had blood cell counts determined within 12 hours of the positive blood culture. Results of the leukocyte response are shown in Table 5. Forty-three of the patients had a leukocyte count greater than 10,000/cu mm. Only 12 had a white blood cell count (WBC) greater than 20,000/cu mm. Three had very high counts (greater than 100,000/cu mm) as a manifestation of acute leukemia. Of the ten patients with WBC counts less than 5,000/cu mm, eight had a hematologic disease (leukemia, aplastic anemia, and others). Two of these survived — one with cyclic neutropenia and the other with spontaneous remission of idiopathic aplastic anemia. The mortality rates were highest in those patients with blood dyscrasias.

Table 6 shows the primary sites of infection for the bacteremias. Such designation was based on recorded clinical findings and/or the results of cultured material from such sites. Because there often is a close clinical similarity between the presentation of gastrointestinal tract disease (right-sided diverticulitis) and biliary tract disease (cholecystitis), these two sources of bacteremia are included together. The urinary tract was the portal of entry in 35 of the cases, and the gastrointestinal-biliary tract in 13. Furthermore, *E. coli,* Proteus, and Klebsiella organisms combined to represent 93 percent of all bacteremia coming from the urinary tract, whereas Bacteroides and *E. coli* represented 74 percent of those coming from the gastrointestinal-biliary tract. There were four cases of bacteremia felt to be a complication of pneumonia. Two of these, one caused by Pseudomonas and the other by Pasteurella *(P. multocida)*, were associated with a hematologic malignancy. Another was a patient with oat cell carcinoma of the lung and Serratia pneumonia (patient mentioned previously as being without fever). The female genital tract and the skin were the source of two cases and one case, respectively; no source could be designated in 15 episodes of bacteremia.

For the 73 isolates tested, Table 7 lists the percentage of those sensitive to various antibiotics. Also included are two antibiotic combinations frequently used. Because of the major importance of the urinary tract and the gastrointestinal-biliary tract as sources for bacteremia, these groups also are analyzed separately. Since no sensitivity tests were performed for the *Bacteroides species,* it was assumed they all demonstrated a standard sensitivity pattern of *B. fragilis* — sensitive to only chloramphenicol or clindamycin of the antibiotics listed. It also should be noted that carbenicillin was not included in the list because it was not as commonly used at Riverside Hospital at the time of this study.

One hundred percent of the isolates showed sensitivity to the combination of clindamycin and gentamicin (implying that either of these antibiotics was effective in vitro). In addition, however, 100 percent of those isolates of bacteremia from a gastrointestinal-biliary source were sensitive to chloramphenicol, and 100 percent of those from the urinary tract were sensitive to gentamicin.

Discussion

Because of the major clinical significance of gram-negative bacteremia, it is important that the physician be knowledgeable concerning the pattern of this infection within his own hospital practice. Since a substantial percentage of the nation's physicians are practicing in a community hospital, it is important to analyze the spectrum of such infections in this setting. Riverside Methodist

Hospital, the setting of this report, can be considered as a large community hospital.

The incidence of gram-negative bacteremia in this report is somewhat lower than in most other recent series.[1,5-7] Both the 0.24 percent rate when compiled over the entire year and the 0.45 percent rate when compiled over the last three months of the study represent a smaller attack rate than the 1 to 2 percent rate as previously indicated. The lower incidence in this study tends to support the opinion that national extrapolations — based on studies from teaching centers — may be overestimates. It stands to reason that university medical centers might have a higher incidence of gram-negative bacteremia. It is inherent in their function to see patients with more complex medical problems often associated with newer diagnostic or therapeutic techniques (eg, immunosuppressive therapy).

In both the community and the university hospital, however, it is clear that a variety of factors have contributed to the increased incidence of these infections.[1,3,4,7] Surgical procedures and instrumentation within the intestinal (including sigmoidoscopy[8]), urinary, or respiratory tracts are predisposing factors. Certain conditions of impaired host immunity, such as malignancies, immunosuppressive drugs, and steroids, enhance susceptibility. Patients with diabetes mellitus, cirrhosis, and other chronic illnesses have an increased incidence of gram-negative-rod infections. Recent treatment with antibiotics tends to promote emergence of gram-negative organisms. In addition, medical devices — including indwelling Foley catheters, intravenous catheters, and inhalation machines — tend to predispose the patient to such infections. There is an association of gram-negative bacteremia with these various predisposing factors at RMH (Table 3).

Interestingly and in comparison to the findings of others,[5,6] the number of nonhospital-associated bacteremia cases was greater than the number of hospital associated infections in this study (Table 1). This factor again probably is related to the difference between the community hospital and the teaching center. One might expect a higher proportion of bacteremia in the community hospital to be among patients who were admitted because of the bacteremia. Such a patient perhaps is less likely to have as severe an underlying disease or other predisposing factor, as indicated herein, than the patient who is already in the hospital and develops a nosocomial infection. This might explain the lower mortality rate of 20 percent of the patients with nonhospital-associated, gram-negative bacteremia, when compared to the mortality rate of 45 percent of the hospital-associated bacteremia cases. Despite this increase in proportion of nonhospital-associated bacteremia, the 31 percent overall mortality rate from this study remains consistent with that of previous studies.[1,5,6]

With only a slight variation, the prevalence of species-specific bacteremia in this report follows the trend nationwide (Table 5). *E. coli* was the most frequent cause of gram-negative bacteremia, most likely reflecting the high frequency of the urinary tract as the source of bacteremia. This was followed by the Proteus group and Klebsiella-Enterobacter-Serratia (KES) group. The incidence of the KES group has particularly increased nationwide within the last decade and has caused more bacteremia than *E. coli,* according to some reports.[6] Bacteroides bacteremia was well represented in this series (12 percent). This is consistent with a general increasing awareness of all anaerobic infections, which is occurring in part as a result of recent advances in anaerobic bacteriology. Eight percent of the bacteremias were caused by Pseudomonas, and all but one were in patients with a hematologic disease.

Considering the mortality rate for each specific group, *E. coli* had a relatively low rate of 18 percent, compared with the mortality rates of 44 percent for Klebsiella and 83 percent for Pseudomonas. The difference in mortality rates of the various species may reflect an increased association of the KES group and Pseudomonas with immunosuppressed patients and with nosocomial infections.

The high mortality rate from such infections requires rapid diagnosis and subsequent treatment. The recognition of the clinical manifestations of gram-negative sepsis, therefore, is very important. Thus, chills with temperature elevation and hypotension, particularly in patients with any predisposing condition, should suggest gram-negative bacteremia. Additional signs and symptoms may be hyperpnea, tachypnea, respiratory alkalosis, oliguria,

TABLE 7. Isolate Sensitivity to Antibiotics

Isolates	Sensitivity %
Total	
Ampicillin	54
Cephalothin	59
Gentamicin	84
Chloramphenicol*	95
Cephalothin and gentamicin	86
Clindamycin* and gentamicin	100
Gastrointestinal-bilary tract	
Ampicillin	39
Cephalothin	59
Gentamicin	61
Chloramphenicol	100
Cephalothin and gentamicin	67
Clindamycin and gentamicin	100
Urinary tract	
Ampicillin	68
Cephalothin	72
Gentamicin	100
Chloramphenicol	90
Cephalothin and gentamicin	100
Clindamycin and gentamicin	100

*Since no sensitivity tests were performed for the *Bacteroids species* (assuming *B. fragilis),* it was assumed these isolates were sensitive to chloramphenicol and clindamycin but resistant to the other antibiotics listed.

hypotension alone, thrombocytopenia, a decrease in mentation, and even hypothermia in the susceptible patient.

This report analyzes two easily obtainable clinical measurements and compares them with survival. Ninety-three percent of the patients had a febrile response at the time of the culture, with 80 percent manifesting a temperature greater than 38.8 C (102 F). This is not surprising since it is the temperature elevation that signals the bacteremia in most cases and is almost a universal finding in gram-negative bacteremia. Dupont and Spink[5] found 97 percent of the cases to have temperatures recorded at greater than 37.7 C (100 F). Because fever is the usual signal for the drawing of blood cultures, this high frequency of fever associated with gram-negative bacteremia may be falsely high. This is so because bacteremia may occur without febrile response — especially in those patients receiving steroids, the elderly, or those with severe infections. In the present series, four patients were afebrile; all four of them died. While hypothermia is felt to have a grave prognosis,[5] none of the patients in this series was hypothermic at the time of culture.

It is difficult to characterize the results of the leukocyte response in these patients. Most of them (74 percent) had a leukocyte count greater than 10,000/cu mm, but only 21 percent of them were greater than 20,000/cu mm. Some of the latter had high counts as a manifestation of a hematologic malignancy. Of those with a leukocyte count less than 5,000/cu mm (ten), eight had a hematologic disease (leukemia, aplastic anemia). Two of these survived. The high mortality rate of those patients with a leukocyte count greater than 20,000/cu mm or less than 5,000/cu mm (50 percent and 80 percent respectively) probably reflects the high association of these groups with hematologic malignancies.

In general, the characteristic finding in most infections with bacteremia is a polymorphonuclear leukocytosis. It should be realized, however, that there may be a transient leukopenia associated with gram-negative bacteremias. The presence of bacteria within the blood stream may be followed immediately by a sharp reduction in leukocytes resulting from margination and sequestering of leukocytes in the capillary beds. This may be followed by a "rebound" leukocytosis as a result of the release of cells from the marginated pool and the bone marrow. Depending upon the time of obtaining the blood in relation to this "rebound" effect, a misleading value may result.[9]

The urinary tract and the gastrointestinal-biliary tract were the most frequent sources for the gram-negative bacteremia in this study (Table 6). It is important to note the difference in the specific organisms from the two sources of infection. Whereas *E. coli,* Proteus, and Klebsiella were the major etiologic agents of all the urinary-tract-associated bacteremia, Bacteroides was an important cause coming from the gastrointestinal-biliary tract.

An awareness of such a difference in types of pathogens isolated from the different sources of infection is important therapeutically. Consideration of the most likely pathogen and estimates of its antimicrobial sensitivity are essential in selection of an initial antibiotic regimen. In the clinical setting of a critically ill patient with suspected gram-negative bacteremia, one must attempt to choose an effective regimen without waiting for culture data. However, an evaluation of a gram stain of any appropriate specimen or buffy coat from a spun specimen of blood is manditory before a logical choice can be made. At least this procedure can confirm the presence of gram-negative organisms.

The findings of this report would suggest that for gram-negative bacteremia suspected to have originated from the urinary tract, the use of gentamicin prior to the results of cultures would seem reasonable. In the face of suspected gram-negative sepsis from the gastrointestinal-biliary tract, the selection of antibiotics presents a different problem. In this situation, Bacteroides, particularly *B. fragilis,* is a definite possibility, especially in conditions involving the bowel distal to the terminal ileum. Therefore, a combination of clindamycin and gentamicin prior to the results of cultures seems appropriate. This combination also may be reasonable therapy for the critically ill obstetric or gynecologic patient with suspected sepsis since the causative organisms in patients with septic abortion, postoperative pelvic infection, and puerperal infection often include aerobic gram-negative bacilli or anaerobic bacilli.

Fixed antibiotic regimens have merit only if used judiciously. No combination of antibiotics can cover all gram-positive and gram-negative organisms or is appropriate for every clinical situation. Therefore, the combination of carbenicillin and gentamicin may be more appropriate for the patient with granulocytopenia because of a synergistic effect on Pseudomonas. In addition, Enterococcus, a gram-positive organism for which ampicillin is the drug of choice, may be a cause of bacteremia associated with either urinary-tract or gastrointestinal-biliary-tract infections. Finally, all antibiotic regimens must be reconsidered after the results of cultures and sensitivities are obtained.

Conclusions

1. Evidence is presented which indicates the incidence of gram-negative bacteremia is less in the community hospital than in the university center. Therefore, national extrapolations based on studies from university centers may be overestimates.

2. The overall mortality rate for these infections in a community hospital is similar to that within the university center.

3. Contrary to the findings of previous studies, the majority of cases of gram-negative bacteremia at RMH are in patients with nonhospital-associated infections.

4. An elevated temperature and an elevated white blood cell count are two easily determined parameters which are found in the majority of cases of gram-negative

bacteremia. However, a small minority of bacteremia cases show neither. The mortality rate is highest in those patients with leukopenia.

5. During the period of this study at RMH, *E. coli,* Proteus, and Klebsiella combined to represent 93 percent of all cases of bacteremia coming from the urinary tract, whereas Bacteroides and *E. coli,* represented 74 percent of those coming from the gastrointestinal-bilary tract.

6. On the basis of in vitro sensitivities, all organisms isolated from the blood in those patients with bacteremia suspected to have originated from the urinary tract were susceptible to gentamicin. All organisms isolated from the blood of gastrointestinal-biliary-tract related bacteremia were susceptible to either clindamycin or gentamicin.

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Hematologic Side-Effects of Dapsone

John R. Wilson, M.D.
John W. Harris, M.D.

Dapsane is a bacteriastatic agent used ta treat leprosy and a variety of dermatalogic disarders and as a praphylaxis against falciparum malaria. Its side-effects include a mananucleasis-like syndrame, nausea, skin rashes, blurred visian, peripheral neurapathy, and a variety af hematalogic changes. This report describes three patients each af wham develaped a majar hematalogic side-effect af dapsone: agranulacytasis, methemaglabinemia, and hemalysis. The clinical caurse af these side-effects is defined and the mechanisms by which dapsane is thaught ta cause hematalagic damage are discussed.

THE SULFONES, of which dapsone is a member, are a group of drugs with a mechanism of action similar to that of the sulfonamides: interference with folate synthesis. Dapsone was synthesized first in 1908 and initially used primarily to treat leprosy. More recently, it also has been widely used to treat several dermatologic disorders, particularly dermatitis herpetiformis, and as prophylaxis against falciparum malaria.[1]

For reasons not yet completely understood, dapsone is predictably a toxic agent even when used in relatively small dosages. In particular, it appears to be toxic to the hematopoietic system. When used in therapeutic dosages, it routinely causes a mild increase in methemoglobin levels and a mild-to-moderate degree of hemolysis. It also causes agranulocytosis in certain individuals.

During the course of several months, we have seen all three of these toxic effects develop in patients being cared for in our clinical services. We report here the clinical course of three patients to emphasize both the prevalence and potential severity of dapsone's hematologic side-effects and to discuss the mechanisms which underlie these side-effects. Clinical data on two of the patients illustrate problems not dealt with previously in the literature: dapsone poisoning in the adult and the continued use of high dosages of dapsone in the face of significant dapsone-induced hemolysis.

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Clinical Observations

Patient 1. — A 49-year-old diabetic, white man with rheumatoid arthritis was admitted to the hospital for treatment of epididymitis. He had been started on dapsone therapy, 300 mg daily, 18 months previously for long-standing hidradenitis suppurativa. One month before admission, the patient's leukocyte count was 5,000/cu mm with 49 percent polymorphonuclear cells, 45 percent lymphocytes, and 6 percent monocytes.

On admission, the leukocyte count was 4,700/cu mm with 65 percent polymorphonuclear cells and 7 percent bands (Table 1). Intravenous ampicillin therapy was begun resulting in improvement of the epididymitis. Three days later, the patient's urine culture grew pseudomonas resistant to ampicillin. Ampicillin therapy was discontinued and a regimen of gentamycin was begun.

On the eighth day of hospitalization, the patient's temperature rose to over 39 C and he complained of intermittent sweats and myalgias. Six days later, he developed a nonpruritic petechial rash over all extremities. The following day, his leukocyte count was 3,100/cu mm with 2 percent polymorphonuclear cells and 2 percent bands. A bone marrow aspirate showed a normal myeloid-erythroid ratio but with almost complete absence of metamyelocytes, bands, and mature polymorphonuclear cells. All medications except insulin were discontinued.

Within two days, the patient's rash began to fade, his temperature returned to normal, and his symptoms departed. Four days later, young myeloid cells began to appear in the peripheral blood. Ten days after the drug therapy was discontinued, the leukocyte count was 3,700/cu mm with 37 percent polymorphonuclear cells, and 5 percent bands.

Patient 2. — A 21-year-old white man, a nephew of the patient previously described herein, was admitted to

the hospital for evaluation of cyanosis. At 9 PM on the evening of admission, he had ingested 1.0 to 1.5 gm of his uncle's dapsone in a suicidal attempt. Later that evening, he had been admitted to a psychiatric service fully conscious and without complaints. The following morning, he was noted to be intensely cyanotic and was transferred to a general medical service.

On arrival, the patient was cyanotic but otherwise appeared well. He denied having headache and nausea. His hematocrit value was 48 percent, hemoglobin was 17.6 gm/100 ml, leukocyte count 12,100/cu mm with 68 percent polymorphonuclear cells, arterial P_{O_2} value was 66 mm Hg, P_{CO_2} 27 mm Hg, pH 7.50, and erythrocyte glucose-6-phosphate dehydrogenase (G6PD) levels normal. A methemoglobin level determined within one hour of drawing the blood revealed 22 percent methemoglobin. A peripheral smear showed a slight increase in Heinz bodies.

Repeat methemoglobin levels obtained over the following two days showed gradual clearing of the methemoglobin, undetectable levels being reached within 48 hours (Table 2).

Patient 3. — A 39-year-old white woman was started on dapsone therapy, 200 mg daily, for Behcet's disease. Numerous hematocrit values obtained prior to starting the dapsone therapy had ranged between 38 and 42 percent with reticulocyte counts of 1 to 3 percent. Erythrocyte G6PD levels were normal.

Following the initiation of dapsone, the patient's clinical status improved slightly, while her hematocrit value remained between 37 and 39 percent with reticulocyte counts of 4 to 6 percent. At the end of two months, the dapsone dosage was increased to 300 mg daily in the hopes of bringing about further improvement. This resulted in a dapsone level of 6.8 mg/liter when drawn eight hours after the dose. Within two weeks, the hematocrit level dropped to 28 to 32 percent and the reticulocyte count rose to 10 to 15 percent. Result of a peripheral blood smear was unremarkable. Results of direct and indirect Coombs test were negative. There was no increase in Heinz bodies. Three weeks later, the hematocrit level had stabilized at 30 to 33 percent with reticulocyte counts of 4 to 7 percent.

Discussion

Dapsone (4,4'-diaminodiphenylsulfone) is almost completely absorbed from the gastrointestinal tract, peak plasma levels being reached in one to three hours. On conventional dosages of 50 to 100 mg daily, dapsone levels run between 1 and 2 mg/liter. Seventy to 80 percent of a dose is excreted in the urine as acid-labile N-glucoronides, mono-N-sulfamates, and other unidentified metabolites. Because of an enterohepatic circulation, dapsone may be detected in the plasma 8 to 12 days after a single dose and up to 35 days after multiple doses. Other side-effects of the drug include an infectious mononucleosis-like syndrome, anorexia, peripheral neuropathy, nausea, headaches, blurred vision, and skin rashes.

Agranulocytosis due to dapsone therapy, although infrequent, has been reported on a number of occasions.[2-6] It appears to be an idiosyncratic reaction unrelated to dosage. Methemoglobinemia[1] and hemolysis,[8,9] on the other hand, occur to some degree in all patients taking dapsone. For these reactions, the severity of the process is dose-related.

The agranulocytosis in our first patient seemed most likely due to dapsone for several reasons: (1) fever and rash are commonly reported with dapsone-induced agranulocytosis; (2) there is a strong association of dapsone with agranulocytosis; and (3) the agranulocytosis immediately improved after dapsone therapy was discontinued. Of the other medications taken by the patient, only gentamycin has been clearly associated with agranulocytosis.[10] It is possible that the gentamycin was responsible for the agranulocytosis. However, because only one case of gentamycin-induced agranulocytosis has been reported in the literature — and that in a patient who exhibited no constitutional symptoms during the development of agranulocytosis — we think it unlikely that gentamycin caused the agranulocytosis in our patient.

Dapsone-induced agranulocytosis produces a distinctive clinical picture. The patient usually has been taking the drug for several weeks to several months when the agranulocytosis occurs. The onset almost always is heralded by a fever and commonly is associated with a rash over the extremities and with pharyngitis. When obtained early, the bone marrow shows an absence or marked reduction of recognizable granulocyte precursors. Unless the patient succumbs to an infection, recovery usually occurs in two to nine days following withdrawal of the drug.

Drug-induced agranulocytosis usually is due to either the production of leukocyte antibodies or to direct bone marrow toxicity. The mechanism of dapsone-induced agranulocytosis is unknown but clinically fits the former mechanism best.

To detect leukocyte antibodies, serum, drug, and leukocytes are incubated and then observed for leukoagglutination or damage to white cell function. Using this technique, only one drug — aminopyrine, an analgesic and antipyretic agent widely used between 1920 and 1940 — has been shown to commonly form leukoagglutinins. The clinical picture seen with aminopyrine-induced agranulocytosis includes a variable period between 4 and 300 days during which the granulocytes are normal followed by the abrupt onset of chills and fever, postulated to be due to pyrogen release from destroyed granulocytes, and agranulocytosis. This picture is almost identical with that seen in dapsone-induced agranulocytosis.

Unless infection is present, the agranulocytosis due to direct bone marrow toxicity usually is not associated with any symptoms. The mechanisms which may account for this toxicity have been reviewed recently by Pisciotta.[11]

Table 1. Results of Peripheral Blood Cell Counts in Patient No. 1.

	HOSPITAL DAY					
	1	15*	16	19	25	32
Hematocrit (% vol. of cells)	34.2	25.1	25.8	28.3	30.1	33.1
White blood cells/cu mm	4.7	3.1	2.2	4.3	3.7	4.2
Polymorphonuclear	65.0	2.0	1.0	4.0	37.0	32.0
Bands	7.0	2.0	1.0	13.0	5.0	12.0
Eosinophils	0.0	5.0	7.0	3.0	3.0	3.0
Lymphocytes	23.0	72.0	79.0	63.0	49.0	42.0
Monocytes	5.0	18.0	12.0	11.0	6.0	10.0
Myelocytes	0.0	1.0	0.0	3.0	0.0	0.0
Metamyelocytes	0.0	0.0	0.0	1.0	0.0	1.0
Platelets	321,000	171,000		270,000		

*All drugs except insulin discontinued.

His work with chlorpromazine-induced agranulocytosis and the work of other investigators have suggested that many drugs, originally thought to cause agranulocytosis by idiosyncratic reaction in only an occasional individual, may, in fact, damage the granulocytic precursors of normal individuals as well. In those susceptible to the induction of agranulocytosis, there appears to exist a unique inability to compensate for minimal bone marrow damage. Their granulocytic precursors are unable to divide as rapidly as in normal individuals. Consequently, if such a patient continues to receive a drug that is toxic to the marrow for a sufficient length of time, overt agranulocytosis eventually ensues.

Less serious than agranulocytosis but considerably more frequent is the side-effect illustrated by our second patient — methemoglobinemia. Methemoglobin is hemoglobin with its iron in the oxidized or ferric state, a form that no longer can reversibly bind oxygen. It is formed normally in small amounts from ferrohemoglobin during the binding and release of oxygen, but it also can be formed in much larger amounts by such oxidizing agents as dapsone. In the absence of oxidizing agents, the methemoglobin reductases present in red cells are able to keep the metheglobin levels below 1 percent. However, when an oxidizing agent is present, methemoglobin may be generated in sufficient quantities to overwhelm the reductases and produce much higher levels. Levels to 30 to 50 percent methemoglobin may cause fatigue, headache, nausea, and vomiting while levels in excess of 50 percent can lead to stupor, coma, and death.

Dapsone, being a strong oxidizing agent, causes a dose-dependent increase in methemoglobin levels in everyone. However, when it is used in therapeutic doses — less than 400 mg daily — the degree of methemoglobinemia usually does not become clinically significant. At doses of 200 mg daily, methemoglobin levels in normal patients rarely exceed 7 percent and usually range between 1 and 3 percent.[7] Doses of 300 mg can cause methemoglobin levels up to 20 percent.

In contrast, poisoning with dapsone often results in high levels of methemoglobin.[12-14] All prior reports of such poisoning have been in young children and have been of sufficient severity to require treatment with methylene blue. Our experience suggests that in adults, even though extremely high dapsone levels may be present, the methemoglobinemia usually can be treated supportively. With intact reductase systems, the methemoglobin levels should fall to harmless levels within three days. Intravenous methylene blue may be required if clinical deterioration is evident, if the methemoglobin levels are over 50 percent, or if the levels are rising rapidly. Because of the ability of red cells to reduce methemoglobin, blood samples drawn for methemoglobin determinations must be processed immediately. Any delay results in falsely low values such as illustrated in Table 2.

The hemolysis due to dapsone, as distinct from the hemolysis which dapsone and many other drugs can precipitate in patients who are G6PD-deficient, is a universal and relatively mild phenomenon which does not necessarily require discontinuation of the drug. In most patients receiving less than 200 mg daily, the red cell survival is reduced to one-third to one-fourth normal, a level not likely to result in overt anemia in patients with normally responsive bone marrows.[8,9] It is only when dapsone dosages are increased to 300 mg or above — as it was in our patient — that hemolysis becomes more pronounced. Three out of four normal volunteers given 300 mg of dapsone daily by DeGowin, et al[9] developed a decrease

Table 2. Methemoglobin and Dapsone Levels in Patient No. 2.

Day	Hospital Hour	Methemoglobin[18] (gm/100 ml)	%	Methemoglobin % After 18 Hours Incubation	Dapsone Level[19] (mg/liter)
1	9:00 PM	Ingestion			
2	11:30 AM	3.6	22.1	6.9	13.5
	4:00 PM	4.4	26.0	8.5	11.2
3	9:30 AM	1.46	8.4	0.0	7.7
	3:15 PM	1.32	8.8	0.0	5.1
4	9:00 AM	0.0	0.0	0.0	4.1
	1:00 PM	0.0	0.0	0.0	2.9

in hematocrit value of 20 to 25 percent within three weeks. Continued use of the drug at that dosage for an additional one to two weeks did not lead to any further decrease.

The hemolytic effects of dapsone appear to be related to certain drug-induced changes in the red cell membrane. Rasbridge and Scott have shown that, although red cells from patients receiving dapsone have normal osmotic fragility and do not leak potassium, on incubation the cells showed increased autohemolysis.[15] The amount of lysis appears to be directly related to the dosage of dapsone and is paralleled by a loss of red cell phospholipids. Their explanation for the phospholipid loss is that dapsone, being an oxidizing agent, attacks membrane lipids either directly or via the production of hydrogen peroxide. This results in lipid peroxidation which, in turn, damages the stability of red cell membranes making them unusually susceptible to hemolysis.

To support this hypothesis are their observations that red cells from patients receiving dapsone are unusually sensitive to exposure to hydrogen peroxide, and that incubation of such cells with p-chloromercuribenzoate (PCMB), a chemical known to block membrane sulfhydryl groups, results in greater leakage of potassium and hemolysis than is seen with normal red cells. They also have documented that such cells have a relative increase in hexose monophosphate pathway activity and a relative reduction in glutathione levels when compared to normal cells.[16] These changes well may represent an attempt by red cells to compensate for dapsone-induced lipid peroxidation.

More direct evidence for in vivo red cell lipid peroxidation in patients taking dapsone comes from the recent work of Goldstein and McDonagh.[17] These investigators have measured, by spectrofluorescent techniques, the presence in red cell membranes of a fluorescent compound formed by the crosslinking of amino groups of membrane proteins and lipids with malonyldialdehyde (MDA), a decomposition product of oxidized lipids. Whereas red cell membranes taken from normal cells have levels of 17 to 27 fluorescence units, cells taken from six patients receiving dapsone showed levels of 39 to 78 units. These results give tentative support to the hypothesis of Rasbridge and Scott. However, clear confirmation must await future work.

Conclusion

Although dapsone clearly is toxic to the hematopoietic system, as long as it is used in dosages below 300 to 400 mg daily, hemolysis and the production of methemoglobin usually are minimal. Agranulocytosis, on the other hand, is a serious hazard but occurs with sufficient infrequency as not to be a major deterrent to the use of dapsone.

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Does Breast Milk Alone Prevent Iron Deficiency Anemia?

James C. Good, M.D.

The question of possible iron deficiency in breast-fed infants has never been studied through clinical evaluation of normal infants. This study, using a cross section of population and involving 147 breast-fed infants consecutively, shows a very satisfactory level of hemoglobin in the vast majority (145 of 147, or 98.6 percent). Considering the increasing cost of substitute feedings, the high allergy rate seen with the use of cow's milk and early solids, and the convenience of breast feeding, it would seem appropriate to withhold supplemental foods until some definite need for them is apparent. I have shown that iron deficiency anemia does not occur in breast-fed infants as is reported with formula-fed infants.

DOES BREAST MILK ALONE prevent iron deficiency anemia? This critical question is one of the most commonly asked of physicians and nutritionists by mothers of small infants. Much of their concern may be the result of studies of nonfortified, formula-fed infants who frequently show low iron levels, hence, the suggestion of adding iron to the diet or as a medication.[1,2] There seems to be general agreement among nutritionists and physicians that supplemental iron as medication or in enriched foods is necessary for the infant who is fed a cow's milk formula.[3,4] Do breast-fed babies need such supplement? Few studies have been reported in medical literature relative to the hemoglobin values of normal totally breast-fed infants at various stages in their development. This suggests that with normal breast feeding there has not been a problem to cause serious concern.[5-7]

The purpose of this study was to determine what the normal, totally breast-fed infant has as his hemoglobin value at various growth stages, thereby hoping to ascertain with some rationale when iron-containing foods or supplements to the baby's diet are necessary. The early portion of this study was made consecutively on 105 nonselected, breast-fed infants whose mothers represented a cross section of urban population from professional, college women to the less well-educated and the groups striving to keep the basic natural elements of human life. They presented a varied outlook toward infant care and feeding with one parallel — a desire to totally breast feed their infants until there was some definite indication of need to add other foods or supplements. Their pregnancies were all judged to have been normal, and the deliveries, mostly by this author, were normal, with clamping of the umbilical cord delayed until the pulse had stopped in it. All of these women had been given the usual prenatal vitamins with folic acid, and a few were given additional iron when their hemoglobin levels dropped below 11 gm/100 ml. The newborn infants were examined thoroughly and found to be free of any abnormalities that might cause difficulty in their iron metabolism later. The average birth weight of the males was 3.48 kg (7 lb 11 oz), for the females 3.26 kg (7 lb 3 oz), both near the accepted normals.

Hemoglobin Values

Since the life span of the red blood cell usually is accepted to be about 120 days, the age of 4 months was chosen as the first point at which to check the hemoglobin values.* None of the infants had been started on solid foods, vitamins, or iron supplements at this time. In this study, 80 infants checked at age 4 months showed hemoglobin levels ranging from 10.2 gm/100 ml to 15.1 gm/100 ml, with an average of 12.4 gm/100 ml. It is interesting to note that the infant with the lowest hemoglobin value (10.2 gm/100 ml) was one of twins, both of whom had been totally breast fed. Her sister's hemoglobin level was 11.1 gm/100 ml. Comparing these values with the generally accepted levels of infants in the 4-to-12-month age

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*Method of testing hemoglobin was Mallinckrodt Serosonic procedure using the cyanmethemoglobin method as recommended by the Division of Medical Sciences and the National Academy of Sciences. Our laboratory procedure was checked regularly against an outside professional laboratory.

range (10 gm/100 ml to 15 gm/100 ml), our group was found to be well within this range.[6,8-10]

By the time these babies were 8 months old, many of them were taking solids as well as breast milk; a few of them were receiving vitamins and fluoride supplements but none was receiving iron medication. The 31 infants in this group had hemoglobin levels ranging from 9 gm/100 ml to 13 gm/100 ml, with an average of 11.6 gm/100 ml (within the normal range). The one infant with a level of 9 gm/100 ml was the only one below 10 gm/100 ml, and he was placed on a regimen of iron medication and solid foods.

At the age of 1-year-old, all the babies were receiving solids to varying degrees and were still breast feeding. The range of hemoglobin levels for this group of 30 infants was from 9.4 gm/100 ml to 13.7 gm/100 ml, with an average of 11.6 gm/100 ml, the same as for the 8-month-old group. The baby with the 9.4 gm/100 ml level was the only one with a hemoglobin level below 10 gm/100 ml, and he was placed on iron therapy.

With the data collected from the first portion of this study, an additional group of 42 infants was examined at 6 months of age to determine if hemoglobin levels tended to drop in babies who had been solely breast fed for this length of time. In the previous portion of the study, some infants were started on solid foods at 4 months of age, thus, this additional information was thought to be of interest. At 6 months of age, all infants' birth weight had doubled and some well beyond it. They had received no appreciable amount of solids or foods other than breast milk and few were receiving vitamins. None of them was receiving iron in any form except that contained in the breast milk. Their mothers, like the first group, represented a cross section of economic, social, and educational backgrounds, the only common denominator being a sincere desire to do what they felt was best for their babies. The hemoglobin values at 6 months of age ranged from 10 gm/100 ml to 13.7 gm/100 ml, with an average of 11.6 gm/100 ml, the same as that of the 8- and 12-month-old groups. Three babies had levels of exactly 10.0 gm/100 ml and five others' hemoglobin was below the 10.5 gm/100 ml level. All of these were started on solid foods containing meat or other iron-enriched foods to improve their hemoglobin values. None of them had had any significant illness or other disturbance except for rhinitis occasionally. All of the 147 infants in this entire study were weighed and measured at each visit and the statistics charted on the University of Iowa growth charts. It was noted that the male babies in the study followed the 50th percentile line closely all through the first 12 months. The female infants dropped to about the 30th percentile early and stayed in this line all through the first year.

Summary

This two-phase study of hemoglobin values of 147 infants 4 to 12 months old and being either solely or mostly breast fed shows virtually all of them well within the normally accepted levels. There were only two exceptions with below-normal values, suggesting that no other food supplement or iron/vitamin combinations are needed for the majority of normal infants totally breast fed during the ages of 4 to 6 months. Further comparison of growth patterns suggests the infants were growing at a parallel to the standard values for infants. Considering the high cost of substitute milk formulas and prepared baby foods, the obvious economy and other advantages seem to present an argument for breast feeding that is difficult to counter.

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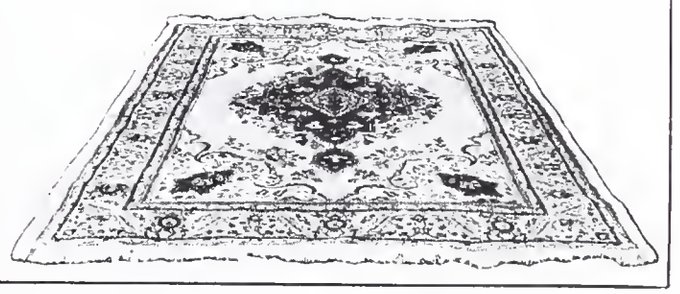
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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Joint Commission on Accreditation of Hospitals Adopts Revised Medical Staff Standards*

Revised medical staff standards were adopted by the Board of Commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) at its April 1977 meeting. The standards have been reorganized into five areas, which are listed below. Essential and applicable requirements of the current medical staff standards were retained and remain in effect.

The new "Medical Staff" section has been published in the *Second Supplement to the 1976 Edition of the Accreditation Manual for Hospitals,* which is available from the JCAH. New provisions will not be effective or a determinant in the accreditation decision-making process until six months after their publication. However, they are consultative for survey purposes.

Qualifications for and Maintenance of Medical Staff Membership

Medical staff membership application forms must provide, as a minimum, information relative to the applicant's medical or dental education and training, professional experience, references who are knowledgeable about his or her competence and ethical character, current licensure, and a specific request for staff assignment(s) and clinical privileges. It is recommended that information also be provided regarding adverse malpractice action, previous or current challenge to licensure or registration, and loss of medical or dental organization membership or medical staff privileges. It is implicit that the applicant must "consent to the inspection by the medical staff credentials committee of pertinent records and documents which are material to an evaluation of his professional and ethical qualifications and his ability to carry out the clinical privileges requested."

Medical staff applicants must also agree "to be bound by the medical staff bylaws and current hospital policies that apply to his activities as a medical staff member and that are consistent with the medical staff bylaws." Previously, the individual agreed to be bound by hospital staff bylaws.

As before, privileges must be delineated for each medical staff member; but under the new wording, the delineation should be reasonably comprehensive, not stated simply as a specialty designated such as "general medicine" or "general surgery," unless such terms are specifically defined in the medical staff bylaws, rules and regulations or in another medical staff or department document. However, "there is no requirement to establish a detailed list of procedures or medical diseases in order to delineate in individual's privileges."

Patients admitted to the hospital for dental or podiatric care must, as before, receive "the same basic medical appraisal as patients admitted for other services."

> . . . this includes the performance and recording of the findings in the medical record by a physician member of the medical staff of an admission history and physical examination and an evaluation of the overall medical risk. Where dental patients are involved, the responsible dentists shall take into account the recommendations of this consultation in the overall assessment of the specific procedure proposed and the effect of the procedure on the patient. Where significant medical abnormality is present, the final decision must be a joint responsibility of the dentists and the medical consultant.

The dentist or podiatrist is responsible for that which is related to dentistry or podiatry respectively, while the physician member of the medical staff is responsible for the care of any medical problem present at the time of admission or that may arise during hospitalization.

The standards recommend that a staff member considered for reappointment be asked to submit to the designated medical staff committee information about

> . . . the privileges requested, with any basis for change; the continuing education effort made since the previous appointment; and the individual's statement relative to any change in health status. The department or major service chief should contribute information relative to the individual's professional performance, judgment, and technical skill where appropriate, including any effect thereon of the staff member's health status.

The individual's performance relative to medical record keeping, required meeting attendance, and service on staff and hospital committees should be considered in the process of reappraisal.

In the case of medical staff members whose appointment or reappointment is contingent upon a faculty appointment of a university medical or dental school, the loss of faculty appointment automatically results in the loss of medical staff membership and clinical privileges in the hospital.

Medical Staff Organization

It is required that an active medical staff be organized in a manner conducive to performing its duties and functions effectively. As before, there may be other staff categories, associate, courtesy, consulting, honorary, and teaching staffs. However, for each of these categories, the medical staff bylaws must stipulate "the voting prerogatives, meeting attendance requirements, staff office and committee membership eligibility, emergency service responsibility, and any geographical residential requirements which may be related to provision of continuous and timely patient care." Provisional status, as well as the granting of temporary and emergency privileges, has been clarified.

Changes in clinical department functions are related to broadening of the department chairman's responsibilities, the exercising of clinical privileges within the depart-

(continued on page 566)

*Information courtesy JCAH Office of Communications.

JCAH Standards *(continued)*

ment, and the need for more specific and relevant documentation of department meetings.

Medical Staff Bylaws, Rules and Regulations

Existing provisions of this standard were retained essentially intact, with minor elaborations. There is now clarification of the medical staff bylaws requirement that establishes fair hearing and appellate review mechanisms in connection with denial of medical staff appointment and reappointment, or the curtailment, suspension, or revocation of privileges.

Another new requirement is that medical staff rules and regulations shall contain the following medical record requirements: (1) the use of symbols and abbreviations only when they have been approved by the medical staff and when there is an explanatory legend; (2) the specific identity of categories of personnel who are qualified to accept and transcribe verbal orders, regardless of the mode of transmission of the orders; (3) the time following admission of the patient in which a history and physical examination must be entered in the medical record; (4) the specific time period in which medical records must be completed following patient discharge; and (5) the entries in medical records which must be dated and authenticated by the responsible practitioner.

Monitoring of Medical Staff Practice and Functions

There shall be continuous monitoring, with enforcement, of those elements of patient care identified in the medical staff or clinical department/service rules and regulations. In addition, ongoing monitoring of medical staff practice shall be provided by the required regular medical staff and clinical department/service meetings and by meetings of committees designated in the medical staff bylaws.

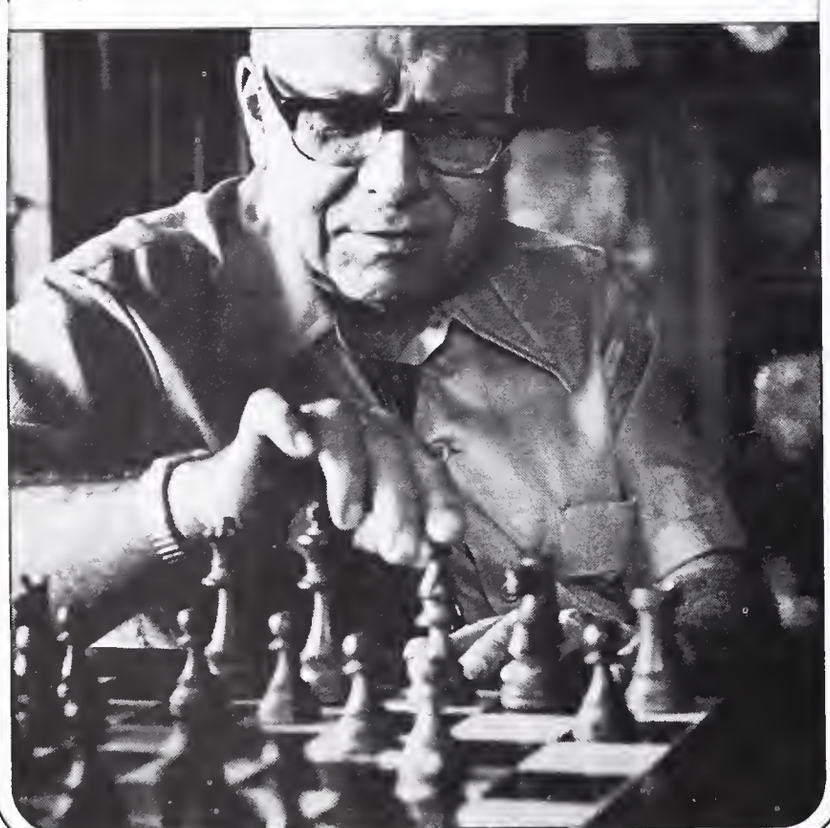
Specific, required functions of the medical staff relate to various elements of patient care, including tissue review, review of pharmacy and therapeutic activities, review of medical records, review of blood utilization, and review of the clinical use of antibiotics. The medical staff must also participate in such functions as infection control, internal and external disaster plans, and the hospital safety committee.

Continuing Professional Education

The elaboration of the existing continuing education requirements for all medical staff members explains that "the scope and complexity of the program shall be determined by the size and diversity of the medical staff, the types of patient care delivered, and documented results of patient care evaluation activities." The relevance of continuing education activities to the care and treatment of patients in the facility is emphasized.

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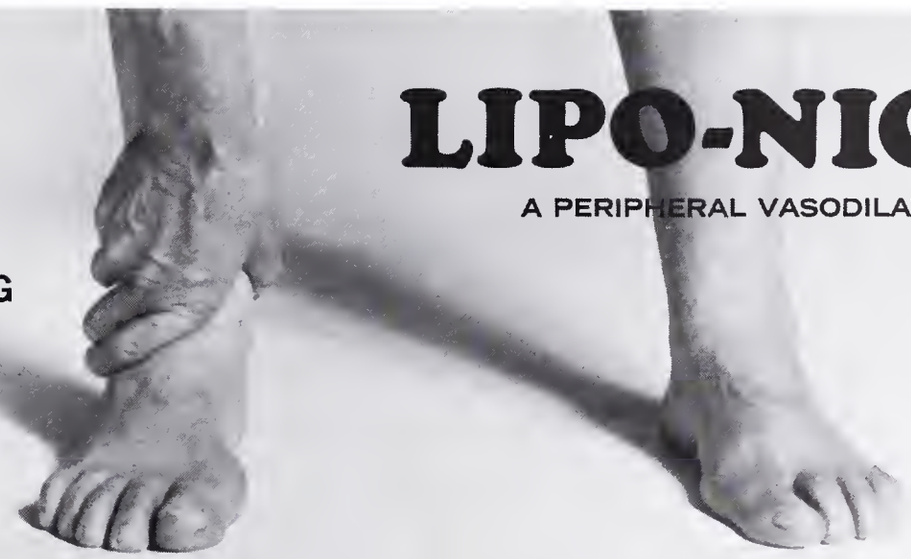
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Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

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Each time-release capsule contains:
Nicotinic Acid .....300 mg.
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Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

The OSMA is cosponsoring with the AMA a Regional Continuing Medical Education Meeting to be held at Sawmill Creek Lodge, Huron, October 7-9, 1977. Fourteen courses certified for Category I credit will be offered. Those courses and their course directors are as follows:

Blood Gases & Electrolytes: Lionel R. King, M.D., Cincinnati (5 credit hours);

Basic Life Support: Mark Popil, M.D., Cincinnati (5 credit hours);

Dermatology for the Nondermatologist: Wilma Bergfeld, M.D., Cleveland (5 credit hours);

Cardiac Arrhythmias, Recognition, Significance, & Treatment: Lon Castle, M.D., Cleveland (5 credit hours);

Concepts of Immunology as Applied in Everyday Practice: John D. Clough, M.D., Cleveland (5 credit hours);

Preventive & Predictive Medicine for Coronary Artery Disease: Jack R. Kirchner, M.D., Cincinnati (5 credit hours);

Fetal & Perinatal Monitoring: Eldridge A. Baker, M.D., and Horacio S. Falciglia, M.D., Cincinnati (5 credit hours);

Chest X-ray & Flat & Upright Abdominal Films: Charles Mueller, M.D., Columbus (5 credit hours);

Office Management: Robert G. Rothring, President, Professional Management Services, and W. Randall Wakefield, President, Wakefield-Stratton Company, Cincinnati (5 credit hours);

Preventive & Predictive Medicine in GI Diseases: Fred B. Tjomas, M.D., Columbus (5 credit hours);

Recognition & Treatment of Common Eye Problems: Ira A. Abrahamson, Jr., M.D., Cincinnati (5 credit hours);

Headache: Robert S. Kunkel, M.D., Cleveland (5 credit hours);

Pulmonary Disease (Chronic Obstructive Lung Disease): Joseph Tomashefski, M.D., Cleveland (5 credit hours); and

Advanced Life Support, Mark Popil, M.D., Cincinnati (14 credit hours).

Single Course Offerings

September 1977

THE CORE CONTENT REVIEW OF FAMILY MEDICINE: September 1977 through February 1978; Self-Assessment Exam; sponsor: Ohio Academy of Family Physicians; cosponsor: Connecticut Academy of Family Physicians; 24 credit hours; fee: AAFP mbr. $40; Non-mbr. $60; Residents $20; contact: Douglas P. Longenecker, M.D., St. Elizabeth Medical Center, 601 Miami Boulevard, West, Dayton 45408, phone: 513/223-5859.

NUCLEAR MEDICINE IN CARDIOLOGY: September 1; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tract, Administrator, Community MedCenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301, ext. 292.

AMERICAN THYROID ASSOCIATION ANNUAL MEETING (Clinical Day Program): September 7, 8:55 AM; Cleveland Plaza Hotel, Cleveland; sponsor: American Thyroid Association; 6 credit hours; contact: Alvin B. Hayles, M.D., Mayo Clinic, Rochester, Minnesota 55901.

NUCLEAR MEDICINE - ULTRASOUND - COMPUTERIZED TOMOGRAPHY, A CONFRONTATION: September 8-10; Marriott Inn, Cleveland; 20 credit hours; fee $400, $250 residents; contact: D. Bruce Sodee, M.D., Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

FIRST DECADE OF BYPASS GRAFT SURGERY FOR CORONARY ARTERY DISEASE: September 15-17; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 15 credit hours; fee: $250; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

38TH ANNUAL MEETING OHIO SOCIETY OF ANESTHESIOLOGISTS: September 17-18; Hilton Inn North, Columbus; sponsor: Ohio Society of Anesthesiologists, cosponor: Ohio State Medical Association; 9 credit hours; fee: $30 nonmember; $15 member, allied health personnel; contact: Nicholas G. DePiero, M.D., 9710 Garfield Boulevard, Garfield Heights 44125, phone: 216/271-1277.

5TH ANNUAL COMBINED MEETING OF THE OHIO CHAPTER, AMERICAN COLLEGE OF PHYSICIANS AND OHIO SOCIETY OF INTERNAL MEDICINE: September 22-24; Kings Island Inn, Mason; sponsor: American College of Physicians; 11 credit hours; fee: $25 member; $40 nonmember; contact: Ms. Vickey McVay, Ohio Society of Internal Medicine, 600 South High Street, Columbus 43215, phone: 614/228-6971.

FAMILY MEDICINE REVIEW: September 26-30; Holiday Inn OSU, Columbus; sponsor: Ohio Academy of Family Physicians; 40 credit hours; fee: $250; contact: Mrs. Florence Landis, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

DERMATOLOGY FOR THE DERMATOLOGIST AND PATHOLOGIST: September 27-28; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

SPORTS MEDICINE OMEN PROGRAM: September 27, 28, 29, 30, and October 1; 1 credit hour; contact: Center for

Continuing Medical Education, The Ohio State University College of Medicine, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

OBSTETRICAL AND GYNECOLOGICAL PROBLEMS: September 28-29; Miami Valley Hospital, Dayton; sponsor: Wright State University School of Medicine Department of Obstetrics and Gynecology; 16 credit hours; fee: $75; contact: Alfred Hicks, II, M.D., 1 Wyoming Street, Dayton, 45409, phone: 513/223-6192.

OBSTETRICS AND GYNECOLOGY SYMPOSIUM: September 28-29; Stouffer's Dayton Plaza Hotel, Dayton; sponsor: Miami Valley Hospital; cosponsor: Wright State University School of Medicine Departments of Postgraduate Medicine and Obstetrics and Gynecology; 16 credit hours; fee: $75; contact: Arlene L. Polster, Program Coordinator, WSU Department of Postgraduate Medicine, Dayton 45401, phone: 513/372-7140.

October 1977

SELECTED TOPICS IN RHEUMATIC DISEASE: October 5-6; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

RECENT ADVANCES IN THE TREATMENT OF CANCER: October 12-13; Bunts Auditorium, Cleveland Clinic; contact: Penn G. Skillern, M.D., Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CURRENT MANAGEMENT OF HEMOPHILIA: October 14; Biltmore Towers Hotel, Dayton; sponsor: Miami Valley Hospital; cosponsor: Wright State University School of Medicine Departments of Postgraduate Medicine and Pediatrics; 7 credit hours; fee: $25; contact: Arlene Polster, Programs Coordinator, WSU Department of Postgraduate Medicine, Dayton 45402, phone: 513/372-7140.

INTRODUCTION TO ELECTROPHYSIOLOGIC ASSESSMENT OF THE AUDITORY SYSTEM: October 14-15; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $150, $75 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

PULMONARY HEART DISEASE: October 26; Kettering Medical Center, Kettering; sponsor: Kettering Medical Center; cosponsor: Wright State University School of Medicine Departments of Postgraduate Medicine and Internal Medicine; 3 credit hours; fee: $10; contact: Arlene Polster, Program Coordinator, WSU Department of Postgraduate Medicine, Dayton 45401, phone: 513/372-7140.

PULMONARY DISORDERS: October 27; Batavia; 3½ credit hours; fee: $15; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

November 1977

PATIENT COMPLIANCE: November 4; Carrousel Inn, Cincinnati: 5 credit hours; fee: $15; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.



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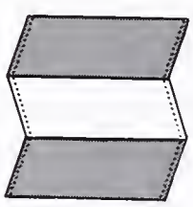
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Colleagues in the News

IRA A. ABRAHAMSON, JR., M.D., Cincinnati, is the author of a recently published book about the eye. *Know Your Eyes* is an introductory text for medical personnel. Sections of the book deal with structure, function, and examination of the eye; problems in different parts of the eye; myths and misconceptions about the eye; emergency eye care; and recent advances in the diagnosis and treatment of eye problems. Dr. Abrahamson is Assistant Clinical Professor of Ophthalmology at the University of Cincinnati School of Medicine.

ELIZABETH R. APLIN, M.D., Columbus, is the 1977 recipient of the John D. Porterfield Distinguished Service Award of the Ohio Public Health Association. Dr. Aplin, Director Emeritus of the Ohio Bureau of Crippled Children's Services, is the third recipient of the Association's highest honor. Having practiced medicine in Gnadenhutten for some 20 years, Dr. Aplin determined to become a pediatrician and enrolled in the residency program at Children's Hospital, Columbus, in 1955. She served on the staff of the Columbus State Institute before becoming head of the Crippled Children's Bureau. Even in retirement, Dr. Aplin continues her activities as consultant to the Ohio Division of Maternal and Child Health, faculty member of The Ohio State University College of Medicine, and chairman of the Ohio Chapter of the American Academy of Pediatrics.

JOHN A. BERGFELD, M.D., Euclid, Head of the Cleveland Clinic's Section on Sports Medicine, has been elected to the Board of Trustees for Medicine and Health Services of the American College of Sports Medicine.

DONALD F. DOHN, M.D., Shaker Heights, Head of the Department of Neurosurgery at the Cleveland Clinic, has been elected president-elect of the American Association of Neurological Surgeons.

LEONARD L. LOVSHIN, M.D., Senior Physician of the Department of General Internal Medicine at the Cleveland Clinic, has been honored by the American Association for the Study of Headache. The Association presented Dr. Lovshin, a pioneer in the study of headache, with its Distinguished Clinician Award.

WALTER J. PORIES, M.D., Cleveland, will be leaving Ohio to become Chairman of the Department of Surgery at East Carolina School of Medicine, Greenville. Dr. Pories is a faculty member of Case Western Reserve University School of Medicine and on the medical staff of Cleveland Metropolitan General Hospital.

In the June 1977 issue of *The Journal* (Vol. 73, No. 6, page 413), the professional status of Dr. Allan E. Blair was incorrectly listed. Dr. Blair is a dentist who specializes in oral surgery. *The Journal* regrets the error.



Some top names in Ohio sports medicine attended the Ohio Valley Conference on sports Medicine, cosponsored by the Ohio Valley Chapter of the Ohio Academy of Family Physicians, the Fort Steuben Medical Foundation, and the Ohio Joint Advisory Committee on Sports Medicine. Pictured left to right: **SANFORD PRESS, M.D.,** Steubenville; **MICHAEL J. VUKSTA, M.D.,** team physician for Youngstown Ursuline High School; **H. ROYER COLLINS, M.D.,** Cleveland; **JOHN N. MEAGHER, M.D.,** Columbus; **ROBERT J. MURPHY, M.D.,** head team physician for The Ohio State University; **TED GEORGEFF, A.T.C.,** head athletic trainer for the Ohio High School All-Star Football Game; and **VIC IPPOLITO, M.D.,** head team physician for the Cleveland Browns.

JACK E. TETIRICK, M.D., Columbus, has been appointed Director of Medical Affairs at Grant Hospital. Dr. Tetirick, who has been a member of the Grant Hospital Medical Staff since 1966, will be responsible for all facets of the hospital's comprehensive medical education program. He served on the hospital's Council on Medical Education for seven years and also chaired the OSMA's Committee on Scientific Work from 1972-1975. Dr. Tetirick is Associate Clinical Professor of Surgery at The Ohio State University College of Medicine, a member of the American Board of Surgery and the American College of Surgeons, and Immediate Past President of the Academy of Medicine of Columbus and Franklin County.

PHILIP A. WEISMAN, M.D., Dayton, has been elected to Candidate Membership in the American Society for Aesthetic Plastic Surgery. Dr. Weisman is a member of the medical staff at Children's Medical Center.

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Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobles

Roosevelt Approves Message Intended to Benefit 30,000,0 Persons When States Adopt Cooperating Laws-He Call the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 19
The Social Security Bill, provid
a broad program of unemploym
insurance and old age pensi
and counted upon to benefit s
20,000,000 persons, became law
day when it was signed by Pr
dent Roosevelt in the presence
those chiefly responsible for p
ting it through Congress.

Mr. Roosevelt called the meas
"the cornerstone in a struct
which is being built but is by
means complete

COMPL

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNE the Draft Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Obituaries

THOMAS T. BAKONDY, M.D., Toledo; Medizinische Fakultat der Universitat Graz, Graz, Austria, 1962; age 57; died May 26; member OSMA.

FREDERICK CROWGEY, M.D., Salem; Western Reserve University School of Medicine, 1924; age 79; died June 4; member OSMA and AMA.

MARION W. JOHNSON, M.D., Greenville; Middlesex University School of Medicine, Waltham, Massachusetts, 1944; age 66; died June 25; member OSMA and AMA.

JOHN E. KICOS, M.D., Canton; St. Louis University School of Medicine, St. Louis, Missouri, 1953; age 54; died May 23; member OSMA and AMA.

JOSEPHINE S. ORR, M.D., Toledo; University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1924; age 79; died June 8; member OSMA and AMA.

JOSEPH D. WALTERS, M.D., Sherman Oaks, California; Ohio State University College of Medicine, 1931; age 74; died May 6.

News *(continued)*

IUD Information to Be Mandatory

Beginning November 1977, physicians must give patients who request intrauterine devices (IUDs) a detailed brochure spelling out the risks and side-effects of IUDs. Patients must be provided with this brochure before the IUD is inserted. The rules, emanating from the Food and Drug Administration, also contain new uniform physician labeling for IUDs.

Kentucky Supreme Court Rules Patients' Fund Unconstitutional

The Kentucky Supreme Court has ruled that the state's Patients' Compensation Fund is unconstitutional. Every physician practicing in Kentucky and every hospital was required to contribute to the fund, which was used for payment of malpractice settlements that exceed a specific amount. The court ruled that the law establishing the compensation fund had attempted to underwrite it "through recourse to the general fund of the state." The decision continued: "This creates a debt and extends the credit of the state, both of which actions are in violation of the state constitution." The court also ruled that the law's provision requiring compulsory malpractice insurance coverage was unconstitutional.

AMA Offers Computer Consultation

The American Medical Association has initiated a new service for the physician community. Known as the AMA Consultative Services Program, the service provides on-site consultative support for physician groups involved in or considering involvement in the use of computers in their practices.

This program was developed because the AMA recognized the potential computers have in the health care setting, while at the same time recognizing that physicians often do not have the time or technical training to efficiently or accurately answer the major questions regarding computer services. For the health care professional who is considering some form of computer services, as well as for current users who want to improve or to expand their computer applications, the AMA Consultative Services Program can provide an objective viewpoint, expertise in both methods and equipment, and the time to evaluate what is desirable for the professional's needs.

The program is limited to activities related to the health care environment. Its services are directed to physician-centered organizations including solo physicians, group practices, clinics, hospitals, and medically related educational institutions, societies, and governmental agencies. Its capabilities extend to all major facets of computer applications in medicine, including the use of computers in clinical activities, medical records, administrative functions, and ancillary services such as clinical laboratories and education.

The goal of the consultant is to provide recommendations for the most advantageous treatment of the particular situation. This could mean manual methods as well as computer-based methods. Three phases comprise a program survey: on-site analysis, detailed analysis of the information collected during the on-site analysis, and preparation of a written report.

The charge for the AMA Consultative Services is $200 per day plus expenses for travel, lodging, and meals incurred to complete the on-site analysis. Expenses will be minimized. A number of days approximately equal to that required for the on-site analysis will be spent at the AMA office doing detailed analysis of the data collected, formulating alternatives, and preparing written recommendations. Therefore, the minimum fee would be $400, with the average fee being $800-$1200 plus expenses.

Physicians interested in this program should contact John A. Guerrieri, Jr., Program Director, AMA Consultative Services Program, 535 N. Dearborn Street, Chicago, Illinois 60610, phone: 312/751-6417.

OSMA Awards Family Practice Scholarships

The OSMA has selected the recipients of its annual Thomas E. Rardin Family Practice Scholarships. The $2,000 scholarships were presented to Kevin R. Berry, Columbus, and Michael L. Sullivan, Marion. Awarded on the basis of a candidate's character, integrity, intelligence, maturity, participation in community life, leadership, scholarship, financial need, and desire to become a family physician, the scholarships are part of the OSMA's continuous effort to encourage young men and women to enter the medical field.

Mr. Berry completed his premedical training at Capital University, Columbus, and will undertake his medical studies at Wright State University School of Medicine.

A graduate of the University of Toledo, Mr. Sullivan will study medicine at The Ohio State University College of Medicine.

In addition to the most recent recipients, there are six other medical students currently receiving Rardin Family Practice Scholarships. They are: Christopher L. Demas, Columbus, The Ohio State University College of Medicine; Gayle Anne Galan, Cleveland, Case Western Reserve University School of Medicine; Aaron R. Folsom, Bellefontaine, The Ohio State University College of Medicine; Thomas G. Trautmann, Cincinnati, University of Cincinnati College of Medicine; G. William Courtright, II, Mount Vernon, Case Western Reserve University School of Medicine; and Elizabeth J. Shreiner, Hinckley, University of Cincinnati College of Medicine.



RARDIN SCHOLARSHIP NOMINEES *LEFT TO RIGHT:* **Row One**— Gladys I. Minor, Oxford; Denise J. Hampton, Dayton; Jasper M. Hedges, M.D., Chairman, OSMA Family Practice Subcommittee; and Doris E. Cattran, Sandusky. **Row Two**— Marc A. Alexander, Cincinnati; Kevin R. Berry, Columbus; Daniel L. Underwood, Westerville; Martin P. Lehenbauer, Deshler; Michael S. McKee, St. Mary's; Michael J. Sullivan, Marion; and David E. Bacha, Youngstown.

Case Western Reserve

JEROME LIEBMAN, M.D., Cleveland, received the Kaiser Permanente Award for Teaching Excellence at the June commencement exercises of Case Western Reserve School of Medicine. Professor of Pediatrics, Dr. Liebman was honored for his clinical teaching. He was cited as "a scholar in medical education who is actively participating in the future of the learning process of this institution." The Kaiser Awards, presented this year for the third time, were established by the Kaiser Foundation Hospitals. Recipients are chosen from nominations made by faculty, students, and alumni.

University of Cincinnati

WILLIAM A. ALTEMEIER, M.D., Professor and Chairman of the Department of Surgery at the University of Cincinnati College of Medicine, has been elected an Honorary Fellow of the Royal College of Surgeons of England. The number of Honorary Fellows in the College of Surgeons does not exceed 80, and the number of those medically qualified does not exceed 60.

RANDALL L. BRADDOM, M.D., Associate Professor and Director of the Department of Physical Medicine and Rehabilitation of the University of Cincinnati College of Medicine, is the newly elected president of the Ohio Society of Physical Medicine and Rehabilitation. Dr. Braddom previously served as vice-president of the Society. A graduate of The Ohio State University College of Medicine, he came to the University of Cincinnati from the Philadelphia Naval Medical Center.

BEVERLY A. CARPENTER, M.D., Assistant Professor of Medicine at the University of Cincinnati College of Medicine, received the Golden Apple award for outstanding clinical teaching at the 1977 medical school commencement. The award is presented by the graduating class.

Also honored at the graduation ceremony was **BENJAMIN FELSON, M.D.,** Professor of Radiology. Dr. Felson received the Gold Medal, highest honor of the American College of Radiology, for his distinguished achievements in medicine. He is former director of the Department of Radiology at the University of Cincinnati College of Medicine.

Northeastern Ohio Universities

The following ten physicians who are serving as chairmen of Clinical Councils for the Northeastern Ohio Universities College of Medicine have been awarded faculty rank by the Board of Trustees of the College:

WILLIAM H. BUNN, JR., M.D., Chief of Medicine, The Youngstown Hospital Association, Associate Professor of Internal Medicine;

WILLIAM A. COOK, M.D., Chief, Department of Obstetrics/Gynecology, Akron General Medical Center, Associate Professor of Obstetrics/Gynecology;

DOUGLAS M. EVANS, M.D., Chief of Surgery, Akron General Medical Center, Associate Professor of Surgery;

WILLARD J. HOWLAND, M.D., Director of Radiology, Aultman Hospital, Canton, Professor of Radiology;

WALTER A. HOYT, JR., M.D., Chairman, Department of Orthopedics, Akron City Hospital and The Children's Hospital of Akron, Professor of Orthopedic Surgery.

HOWARD J. IGEL, M.D., Director of Laboratories, The Children's Hospital of Akron, Professor of Pathology;

JOHN C. JOHNS, M.D., Chairman, Department of Medical Education, Akron General Medical Center, Associate Professor of Internal Medicine;

LOUIS D. KACALIEFF, M.D., Medical Director, Child Guidance Center, Akron, Associate Professor of Psychiatry;

JOHN D. KRAMER, M.D., Director of Pediatric Education, The Children's Hospital of Akron, Associate Professor of Pediatrics; and

JOHN P. SCHLEMMER, M.D., Director, West Side Family Practice Center, Akron General Medical Center, Associate Professor of Family Practice.

Ohio State

LARRY C. CAREY, M.D., Chairman of the Department of Surgery at The Ohio State University College of Medicine, has been named to the Robert M. Zollinger Chair of Surgery at the University in addition to continuing to head the department. He is a member of the Board of Directors of the American Board of Surgery and a Fellow of the American College of Surgeons.

RICHARD L. MEILING, M.D., Consulting Medical Editor of *The Journal,* received an honorary Doctor of Humane Letters degree at the June commencement ceremony of The Ohio State University. Dr. Meiling served as Dean of The Ohio State University College of Medicine, Director of University Hospitals, and Vice-President for Medical Affairs of the University from 1970-1974. He was the first person to be named to the vice-president for medical affairs position. Previous to that appointment, he served as Dean of the College of Medicine and Director of University Hospitals since 1961 and as Associate Dean and Associate Director since 1951.

A 36-year veteran of the United States armed forces, Dr. Meiling holds the rank of Major General in the Air Force Reserve. He pioneered in medical and military procedures used in saving lives of the war wounded; and for these efforts, he received the U.S. Air Force Distinguished Service Medal in 1968.

Dr. Meiling is also a past president of the OSMA and served on the Ohio Delegation to the American Medical Association for 20 years.

The honorary degree presented him read in part:

Richard Lewis Meiling, you have honored your nation, your University, the cause of education and the medical arts by your many contributions to each. As a general officer in the United States Air Force, you have earned praise and honor for your leadership and your efforts to save lives. As a man of science, your research has expanded medical knowledge. As an outstanding leader in medical education, you have merged the skills of learned scholar, educator and administrator to serve as a vice president and dean at this University.



Dr. Meiling (left) and OSU Dean Henry G. Cramblett, M.D. (Photo courtesy the OSU Medical Illustrations Department.)

WILLIAM G. MYERS, M.D., Ph.D., Research Professor of Nuclear Medicine at The Ohio State University College of Medicine, received an honorary Doctor of Science degree during the June commencement at Bucknell University, Lewisburg, Pennsylvania. Dr. Myers is the teacher of the oldest course in nuclear medicine in the world given by a physician and the holder of the distinction of having introduced into medicine more radionuclides than any other single person. In 1973, he was honored by the Society of Nuclear Medicine as the initial recipient of the Paul C. Aebersold Award for "outstanding achievement in basic science applied to nuclear medicine."

Wright State

R. K. BARTHOLOMEW, M.D., Dayton, has been promoted to Professor of Family Practice at Wright State University School of Medicine. Dr. Bartholomew is a member of the medical staff at Children's Medical Center.

RICHARD CAMMERER, M.D.; MARCUS FREESE, M.D.; and **HENRY MAIMON, M.D.,** have been appointed Co-Directors of the Group in Gastroenterology at Wright State University School of Medicine. Doctors Cammerer and Maimon are both Assistant Clinical Professors in the School of Medicine, and Dr. Freese is Associate Clinical Professor.

PAUL GRUNENWALD, M.D.; BENJAMIN SCHUSTER, M.D.; and **SYLVAN WEINBERG, M.D.,** have been appointed Co-Directors of the Group in Cardiology in the Department of Medicine at Wright State University School of Medicine. Doctors Schuster and Weinberg are Clinical Professors in the Department of Medicine, and Dr. Grunenwald is Associate Clinical Professor in the Department.

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INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician who is now completing residency. Board eligible or certified mandatory. Excellent community and hospital. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 389-1312.



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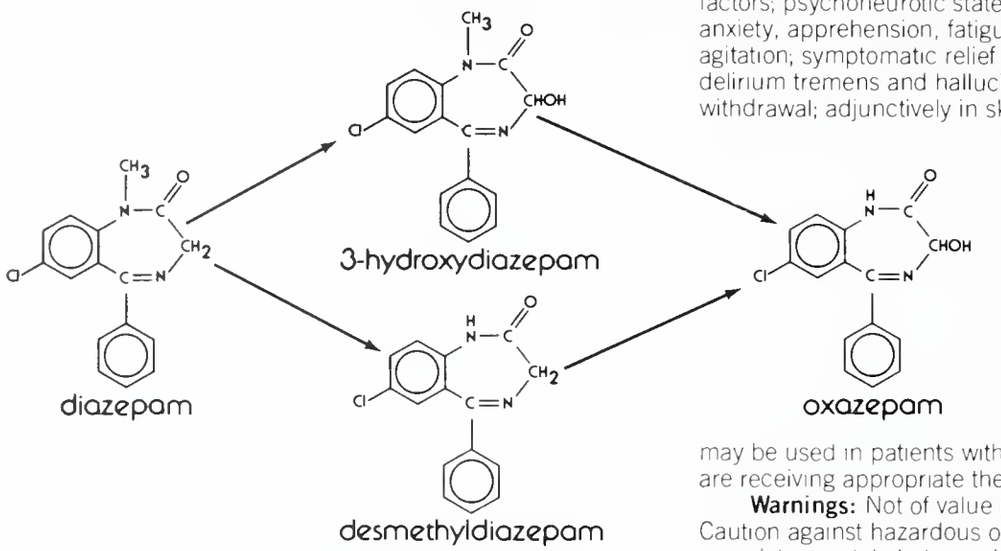
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Report on the Examination of Financial Statements for the Years Ended December 31, 1975 & 1976

Accountants' Report

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1976 and 1975 and the related statements of operations and net worth and changes in financial position for the years then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note 3 to the financial statements, the Association has receivables from a nonprofit corporation of $75,217. Recoverability of the receivables is dependent upon the successful development and marketing of a peer review system for the medical profession. Because of the aforementioned condition, recoverability of the receivables is not determinable.

As described in Note 7 to the financial statements, the Association is the defendant in a legal action which alleges violations of federal and state antitrust laws. Because of the present status of the litigation, the ultimate liability, if any, cannot now be determined.

In our opinion, subject to the effects, if any, on the financial statements of the ultimate resolution of the matters discussed in the preceding paragraphs, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1976 and 1975 and the results of its operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Columbus, Ohio
March 31, 1977

Ohio State Medical Association Balance Sheet, *December 31, 1976 and 1975*

Assets	1976	1975
Current assets:		
Cash	$ 379,667	$ 289,149
Accounts receivable	42,785	21,542
Investment, Physicians Insurance Company of Ohio (PICO), at cost (Notes 9 and 14)	453,000	
Prepaid expenses, including $16,938 in 1976, and $80,737 in 1975, of unamortized pension costs	34,595	88,273
Total current assets	910,047	398,964
Other assets:		
Due from Medical Advances Institute (Note 3)	75,217	75,217
Investments:		
General Trust Fund, at cost which approximates market	43,403	42,037
Ohio Medical Indemnity, Inc., at cost (Notes 6, 7 and 10)	56,000	56,000
Physicians Insurance Company of Ohio (PICO), at cost (Notes 9 and 10)	100,000	
Other	1,857	3,713
	276,477	176,967
Property and equipment, at cost (Notes 1 and 2):		
Land	200,987	200,987
Building	514,020	514,020
Furniture and fixtures	117,972	111,643
	832,979	826,650
Less accumulated depreciation	(95,807)	(72,475)
	737,172	754,175
	$1,923,696	$1,330,106

(Audit continued on page 584)

Liabilities and Net Worth	1976	1975
Current liabilities:		
Accounts payable	$ 85,438	$ 58,472
Current portion, term debt (Note 2)	16,638	90,400
8-¼%, 60-day note payable, bank (Notes 9 and 14)	453,000	
Accrued interest	5,344	1,772
Other current liabilities	138,578	168,685
Total current liabilities	698,998	319,329
Term debt (Note 2)	146,907	238,507
Deferred income:		
Annual membership dues (Note 1)	65,575	98,902
Life membership dues (Note 1)	35,850	31,200
Other	4,131	6,873
	105,556	136,975
Net worth (Notes 7 and 12)	972,235	635,295
	$1,923,696	$1,330,106

(The accompanying notes are an integral part of the financial statements.)

Statement of Operations and Net Worth

For the Years Ended December 31, 1976 and 1975

Income:	1976	1975
Membership dues (Note 1)	$1,232,535	$1,214,487
Membership solicitations—Malpractice Research Fund (Note 11)	238,231	
Exhibit fees	22,440	22,100
Annual meeting	5,453	11,795
Fees for collection of AMA dues	11,444	10,968
CME accreditation and courses	7,407	
Ohio State Medical Journal (Note 8)	62,609	64,509
Interest on savings accounts and certificates of deposit	36,293	21,306
General trust income	1,367	8,338
Rental income	12,569	12,484
Other	3,299	4,024
	1,633,647	1,370,011
Departmental operating expenses:		
Administration	291,942	328,958
Convention coordinator and CME	160,085	97,160
Health education	55,534	55,840
Field service	57,206	66,833
Financial and membership	104,110	104,914
Government medical care	60,949	93,045
Ohio State Medical Journal (Note 8)	169,691	156,304
Organizational services	45,698	56,744
Public relations	116,864	100,485
State legislation	72,178	82,343
Malpractice Research Fund (Note 11)	162,450	
	1,296,707	1,142,626
Net income from operations	336,940	227,385
Net worth, beginning of year	635,295	407,910
Net worth, end of year	$ 972,235	$ 635,295

(The accompanying notes are an integral part of the financial statements.)

Statement of Changes in Financial Position

For the Years Ended December 31, 1976 and 1975

	1976	1975
Source of funds:		
From operations:		
Net income	$336,940	$227,385
Depreciation and amortization not requiring working capital, including $63,800 in 1976 and $70,003 in 1975 relating to pension costs	87,132	92,560
Increase in deferred income (net of $1,350, amortization of life memberships)		7,143
Decrease in unamortized pension cost, net of charges to operations not requiring working capital	(63,800)	28,777
Disposition of equipment, net of accumulated depreciation		47
Other	1,856	1,673
	362,128	357,585
Application of funds:		
Acquisition of property and equipment	6,329	12,489
Increase in General Trust Fund	1,366	8,338
Due from Medical Advances Institute		12,500
Repayment of term debt	91,600	90,400
Decrease in deferred income (net of $1,600, amortization of life memberships)	31,419	
Investment in Physicians Insurance Company of Ohio	100,000	
	230,714	123,727
Increase in working capital	$131,414	$233,858
Changes in the components of working capital:		
Increase (decrease) in current assets:		
Cash	$ 90,518	$163,869
Accounts receivable	21,243	6,738
Investment, Physicians Insurance Company of Ohio	453,000	
Prepaid expense and unamortized costs	(53,678)	29,615
	511,083	200,222
Increase (decrease) in current liabilities:		
Notes payable to bank	453,000	(75,000)
Accounts payable	26,966	(50,913)
Current portion, term debt	(73,762)	1,400
Accrued interest	3,572	(2,583)
Other current liabilities	(30,107)	93,460
	379,669	(33,636)
Increase in working capital	$131,414	$233,858

(The accompanying notes are an integral part of the financial statements.)

Notes to the Financial Statements

1. **Accounting Policies**

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

A. The Association provides for depreciation on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets. Depreciation charged to operations amounted to $23,332 in 1976 and $22,557 in 1975.

B. **Deferred Membership Dues**

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

C. **Prepaid Pension Costs**

At the inception of its qualified pension plan during 1969, the Association fully funded all costs of the plan, which amounted to $386,900.

(Audit continued on page 586)

The prepaid costs are being amortized on an approved actuarial method each year, such annual provision consisting of normal cost plus 10% of the frozen initial liability (past service costs), reduced by interest on the unamortized prepaid costs.

2. **Term Debt**

Term debt at December 31, 1976 consists of an 8% mortgage loan payable in monthly installments of $2,427, including interest, collateralized by land and building, and due July 1, 1984.

3. **Due from Medical Advances Institute**

The Association has advanced $75,217, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio corporation not for profit, to support this organization's development of a peer review system for the medical profession. The recovery of funds advanced to MAI is generally dependent upon the successful development and marketing of the system, which is currently in the developmental stage. The Association believes the system will be successful; however, there has been insufficient operating history and experience to determine the recoverability of the above amount.

4. **Pension Plan**

The Association has a salaried employees' pension plan covering substantially all of its employees. (The Association funded the entire cost of the plan at its inception in 1969—see Note 1). The pension costs for the year 1976 was $63,800 and for 1975, $70,003. The pension costs include normal costs of $59,095 for 1976 and $42,465 for 1975, minimum past service costs of $8,545 for 1976, and maximum past service costs of $34,200 for 1975; reduced by interest of $3,840 for 1976, and $6,662 for 1975 on the unamortized prepaid pension costs. At December 31, 1976 and 1975, the actuarially computed value of vested benefits exceeded plan assets by $135,500 and $36,500, respectively.

The Association has basically completed its amendment of the pension plan in compliance with the Employee Retirement Income Security Act of 1974 (ERISA), and the pension costs for 1976 and 1975 reflect such amendment changes.

5. **Leases**

The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1976:

	1977	1978
Equipment	$13,253	
Automobiles	7,801	$4,036
	$21,054	$4,036

Rental expense under these and similar leases aggregated $32,698 during 1976 and $31,544 during 1975.

6. **Investment—Ohio Medical Indemnity, Inc.**

The Association owns 100% of the outstanding common stock, 8,000 shares, of Ohio Medical Indemnity, Inc. purchased at a cost of $56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) is prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company. In the event of liquidation of the Company, the shareholder (Ohio State Medical Association) shall be paid a sum equal to the price paid for such shares, $56,000. The Company, having an equity of $52,358,000 at December 31, 1976 and $37,135,000 at December 31, 1975, shall at liquidation distribute its remaining assets to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

7. **Contingent Liability**

The Association is the defendant in a civil action brought by the Attorney General of the State of Ohio which alleges violations of federal and state antitrust laws resulting from monopolistic practices. The case is presently pending in the United States District Court, and the plaintiff seeks treble damages and divestiture of ownership in Ohio Medical Indemnity, Inc., the Association's wholly-owned subsidiary.

The Association is vigorously defending the action; however, it is not possible to determine the ultimate outcome of the litigation at this time.

8. **Ohio State Medical Journal**

The income and expenses applicable to the operations of *Ohio State Medical Journal* are as follows:

	1976	1975
Income:		
Advertising (net of commissions of $14,646 in 1976 and $9,337 in 1975 and cash discounts of $911 in 1976 and $831 in 1975)	$ 59,200	$ 63,476
Subscriptions received from nonmembers	3,409	1,033
Membership subscriptions, allocated at $5.75 for 1976, and $4.50 for 1975 per dues-paying member (included in membership dues income on the Statement of Operations and Net Worth)	57,750	47,250
	120,359	111,759
Expenses:		
Salaries, pension costs, payroll taxes and other employee benefits	54,804	48,619
Printing, postage, stationery, supplies, illustrations, engravings, and consulting services	100,593	100,214
Building expenses, depreciation and other	14,294	14,218
	169,691	163,051
Excess of expenses over income, *Ohio State Medical Journal*	$ 49,332	$ 51,292

9. **Investment—Physicians Insurance Company of Ohio**

The Association owns 100% of the Class B common

stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each class of stock has equal rights on a per share basis to participate in dividends and other types of distributions, whether from earnings or in the nature of dividends. Each Class A share is entitled to one vote and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the Class B shares (100 shares), the Association is entitled to 10,000 votes. At December 31, 1976, 3,000 shares of Class A were subscribed and paid for, so that effectively the Association has voting control over PICO. When the total authorized Class A shares (12,000) have been sold, the Class A shareholders will have 55% of the voting control over PICO.

PICO was incorporated September 3, 1976 pursuant to a resolution passed August 1, 1976 by the House of Delegates of the Ohio State Medical Association, to organize a company and provide medical professional liability insurance to its qualified members. PICO obtained its Certificate of Authority from the Department of Insurance of the State of Ohio on December 27, 1976.

Physicians Insurance Company of Ohio had a total stockholders equity of $2,814,177 at December 31, 1976. The Associations equity in PICO totaled $90,780 at December 31, 1976 based on its ownership of 100 shares of Class B common stock.

10. **Insurance Holding Company System**

The insurance holding company system presently consists of three affiliated persons, Ohio State Medical Association (OSMA), Physicians Insurance Company of Ohio (PICO), and Ohio Medical Indemnity, Inc. (OMI).

OSMA owns PICO by virtue of its ownership of 100 shares of Class B common stock of PICO, comprising 100% of such authorized and outstanding shares of stock, and due to the 3,000 Class A shares subscribed and paid for, as aforementioned.

OSMA owns OMI by virtue of its ownership of 100% of the issued and outstanding shares of common stock of OMI.

There exists no relationship or affiliation between PICO and OMI, except that each is owned by OSMA.

11. **Malpractice Research Fund**

In April 1976 the Council of OSMA asked its membership to voluntarily contribute a minimum of $100 to the OSMA Malpractice Research Fund. The membership solicitation for research funds was to finance research projects in connection with the OSMA Task Force on Professional Liability projects, including: Court Docket Survey—liability statistics, Counterclaim Research—legal mechanisms, Captive Malpractice Insurance Company—feasibility, Actuarial Analysis—rates of insurance statistics, and Public Information Campaign.

The income and expenses resulting from the membership solicitation and the task force activities on the above projects are reflected in the accompanying financial statements.

12. **Exemption—Federal Taxes on Income**

The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

13. **Reclassification**

Certain items on the Statement of Operations and Net Worth for 1975 have been reclassified in order to be comparative with 1976.

14. **Physicians Insurance Company of Ohio (PICO), Investment—Current Asset (temporary investment)**

On December 15, 1976, the Association borrowed $1,500,000 under a 8-¼%, 60-day note payable to a bank for the purpose of subscribing and payment for 1,500 shares of PICO Class A common stock. This action was taken in connection with a secondary offering of common shares of stock, and to enable PICO's obtaining its Certificate of Authority from the Department of Insurance of the State of Ohio on December 27, 1976. At December 31, 1976, 453 shares remained unsold under such secondary offering, and the balance of note payable amounted to $453,000. The 1,500 shares of Class A common stock and 100 shares of Class B common stock was collateralized under this note payable. The note payable to the bank was paid in full on January 11, 1977.

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the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Carter Cost Containment Program

Strong pressure from President Carter and other Administration officials and a desire by Congress to get some handle on rising health care costs appear to be weakening Congress' previously firm sentiment against the Administration's Hospital Cost Containment Program. Some Hill observers now believe the plan— in some form or other— is picking up enough momentum to clear Congress this year, a possibility viewed as remote earlier in the session.

The Cost Containment Program calls for imposition of an annual ceiling of about 9 percent on all hospital revenue increases. It places a $2.5 billion limit on capital expenditures. Major health provider groups, including the American Hospital Association and the American Medical Association, have assailed the plan as a revival of the discredited wage and price freeze of several years ago.

Other versions of the Administration's plan, however, are taking shape in the Congress. Here are some recent developments:

(1) Rep. Paul Rogers (D-Fla.), Chairman of the House Commerce Subcommittee on Health, has introduced a modified version of the Administration bill and has held one day of public hearings.

(2) In July, the House Ways and Means Subcommittee on Health, headed by Rep. Dan Rostenkowski (D-Ill.), started marking up a measure following introduction of a version by Rostenkowski.

(3) Sen. Edward Kennedy (D-Mass.) called in his Senate Human Resources Subcommittee on Health to put together a bill containing major elements of the Administration plan.

(4) Sen. Richard Schweiker (R-Pa.) ranking Republican on Kennedy's subcommittee, has introduced an alternative plan that would beef up state control of hospital costs and prohibit capital expenditures for 18 months. Schweiker has been joined by Sen. Thomas McIntyre (D-N.H.).

Public hearings now have been completed on the issue by three of the four Congressional committees with jurisdiction. The exception— the Senate Finance Subcommittee on Health— has conducted public sessions on legislation by Subcommittee Chairman Herman Talmadge (D-Ga.) that is limited to restrictions on Medicare-Medicaid spending by hospitals, but could be broadened to include all revenues.

Congress took a month's vacation during August, and leaders are pushing for an October recess date. This does not leave much time for the four involved committees to resolve their differences and agree on such a volatile issue as controls on one segment of the economy.

The AMA has testified that the Rogers' bill "unfortunately retains those programs which would in effect allow the (HEW) Secretary to determine revenue increases, capital expenditures, and utilization rates." The arbitrary limitations on revenue increases "would prove to be disastrous for many hospitals, especially to the already more efficient hospitals and those hospitals which are located in rural areas," said Edgar T. Beddingfield, Jr., M.D., Chairman of the AMA Council on Legislation.

The major changes made in the Administration plan by Rogers would extend the government's power to regulate the purchase of new major medical equipment, provide incentives for hospitals to eliminate services, and award hospitals for cutting costs. Dr. Beddingfield lauded the concept of incentives, but questioned the details of the new plan.

The AMA Council chairman said that financing incentive payments to hospitals out of general revenues raises Constitutional questions. "Should Congress pay out of the general treasury amounts to hospitals for providing services for which the federal government otherwise has no obligation to pay?" he asked, noting that all inpatients, not just federal beneficiaries, would be covered.

Under the measure, certain equipment purchased for use in a physician's office could be subject to a certification-of-need restriction. Dr. Beddingfield attacked that provision: "Any initial inroads into medical practice seeking to control physician offices or the acquisition of practice equipment would jeopardize the independent practice of professions."

Dr. Beddingfield continued: "Such an action could only lead to more stringent controls eventually controlling practice locations and extent of services available and affecting quality care. Medical practice— the physician's office in particular— should not be treated as a public utility."

The Carter Administration also opposed the amendments recommended by Rogers. Sticking to their game plan of fighting for its proposal with no changes, HEW officials told the House Commerce Health Subcommittee that the suggested changes "have much long-run potential," but "often raise more questions than they resolve."

Karen Davis, Deputy HEW Assistant Secretary for Planning, said: "We simply do not have the time to refine proposals (such as those in the Rogers bill) to ensure that they have the desired effect and preserve administrative simplicity." The Hospital Cost Containment Act as originally proposed should be enacted "as the first and desperately needed step in devising a permanent solution to the critical national problem of controlling rising health costs," she stated.

THE OHIO STATE Medical Association Obituaries

EMIL H. ADLER, M.D., San Diego, California; Case Western Reserve University College of Medicine, 1924; age 77; died July 13; member OSMA and AMA.

RICHARD H. BROOKS, M.D., Columbus; Ohio State University College of Medicine, 1940; age 61; died July 15; member OSMA and AMA.

ARTHUR W. CARLEY, M.D., Dayton; University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, 1912; age 87; died June 23; member OSMA and AMA.

JOHN H. DORNHEGGEN, M.D., Cincinnati; Loyola University Stritch School of Medicine, Maywood, Illinois, 1936; age 68; died July 6; member OSMA and AMA.

JOSEPH A. FERGUS, M.D., St. Paris; Ohio State University School of Medicine, 1934; age 68; died June 27; member OSMA and AMA.

JAMES GRAY, M.D., Cleveland; Case Western Reserve University School of Medicine, 1926; age 77; died June 20; member OSMA and AMA.

WARREN W. HICKS, M.D., Columbus; Ohio State University College of Medicine, 1931; age 75; died July 21; member OSMA and AMA.

DANIEL D. HOSTETLER, M.D., Sugercreek; Case Western Reserve University School of Medicine, 1926; age 80; died June 17; member OSMA and AMA.

THOMAS D. KINNEY, M.D., Durham, North Carolina; Duke University School of Medicine, Durham, North Carolina, 1936; age 68; died June 13.

GERALD W. QUINN, M.D., Port Charlotte, Florida; Case Western Reserve University School of Medicine, 1935; age 68; died March 15; member OSMA.

LILIAN P. SINGER, M.D., Erlanger, Kentucky; Friedrich-Wilhelms Universitat Medizinische Fakultat, Berlin, Prussia (Germany), 1935; age 79; died June 10; member OSMA and AMA.

EUGENE STERNE, M.D., Cincinnati; Harvard Medical School, Boston, Massachusetts, 1937; age 66; died June 15; member OSMA and AMA.

JOSEPH S. STEVENS, M.D., Columbus; Ohio State University College of Medicine, 1922; age 80; died June 14; member OSMA and AMA.

BENJAMIN F. SUFFRON, M.D., Cuyahoga Falls; University of Cincinnati College of Medicine, 1948; age 52; died June 13; member OSMA and AMA.

OTTO WELLNER, M.D., San Diego, California; Medizinische Fakultat der Justus-Liebig Universitat, Giessen, Hessen, Germany, 1926; age 76; died July 1; member OSMA and AMA.

PAULINE ZINNINGER, M.D., North Canton; Johns Hopkins University School of Medicine, Baltimore, Maryland 1923; age 83; died July 11; member OSMA and AMA.



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241/E

OHIO Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated.—L.A.J.*

Single Course Offerings

September 1977

CLINICAL CONCEPTS IN GERIATRICS: September 15; Medical College of Ohio, Toledo; 6 credit hours; registration limit: 100; fee: $35, $20 MCO faculty; contact: Howard S. Madigan, M.D., Medical College of Ohio, C. S. 10008, Toledo, Ohio 43699, phone: 419/381-4237.

DISEASES OF THE COLON AND RECTUM: September 15; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, General Surgery, St. Elizabeth Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

FIRST DECADE OF BYPASS GRAFT SURGERY FOR CORONARY ARTERY DISEASE: September 15-17; Bond Court Hotel, Cleveland; sponsor: The Cleveland Clinic Educational Foundation; 15 credit hours; fee: $250; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

38TH ANNUAL MEETING OHIO SOCIETY OF ANESTHESIOLOGISTS: September 17-18; Hilton Inn North, Columbus; sponsor: Ohio Society of Anesthesiologists, cosponor: Ohio State Medical Association; 9 credit hours; fee: $30 nonmember; $15 member, allied health personnel; contact: Nicholas G. DePiero, M.D., 9710 Garfield Boulevard, Garfield Heights 44125, phone: 216/271-1277.

PEDIATRIC-OB/GYN CONFERENCE: September 18; Steubenville Country Club, Steubenville; 6 credit hours; contact: Sanford Press, M.D., 525 North Fourth Street, Steubenville 43952, phone: 614/282-4893.

OFFICE GYNECOLOGY: September 21; Akron City Hospital; 4 credit hours; fee: $10, $5 students and physician-in-training; contact: Mrs. Linda Kerlee, Akron City Hospital, 525 East Market Street, Akron 44309, phone: 216/375-3203.

5TH ANNUAL COMBINED MEETING OF THE OHIO CHAPTER, AMERICAN COLLEGE OF PHYSICIANS AND OHIO SOCIETY OF INTERNAL MEDICINE: September 22-24; Kings Island Inn, Mason; sponsor: American College of Physicians; 11 credit hours; fee: $25 member; $40 nonmember; contact: Ms. Vickey McVay, Ohio Society of Internal Medicine, 600 South High Street, Columbus 43215, phone: 614/228-6971.

FAMILY MEDICINE REVIEW: September 26-30; Holiday Inn OSU, Columbus; sponsor: Ohio Academy of Family Physicians; 40 credit hours; fee: $250; contact: Mrs. Florence Landis, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

DERMATOLOGY FOR THE DERMATOLOGIST AND PATHOLOGIST: September 27-28; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

SPORTS MEDICINE OMEN PROGRAM: September 27, 28, 29, 30, and October 1; 1 credit hour; contact: Center for Continuing Medical Education, The Ohio State University College of Medicine, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

OBSTETRICAL AND GYNECOLOGICAL PROBLEMS: September 28-29; Miami Valley Hospital, Dayton; sponsor: Wright State University School of Medicine Department of Obstetrics and Gynecology; 16 credit hours; fee: $75; contact: Alfred Hicks, II, M.D., 1 Wyoming Street, Dayton, 45409, phone: 513/223-6192.

REGIONALIZATION OF PERINATAL CARE: ATTEMPT TO REDUCE PERINATAL MORTALITY IN OHIO: September 29; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301, ext. 292.

SCOLIOSIS AND KYPHOSIS (Early Recognition): September 29; University of Cincinnati College of Medicine; sponsor: Department of Orthopaedic Surgery; cosponsor: CONMED, Good Samaritan Hospital; 4 credit hours; fee: $35; contact: Office of CONMED, Dean's Suite E251, College of Medicine, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

PEDIATRICS FOR THE PRACTICING PHYSICIAN: September 30, October 1-2; Holiday Inn of Toledo-Perrysburg, Perrysburg; sponsor: Medical College of Ohio; 14 credit hours; fee: $100 physicians, $35 nurses (various fees for activities); contact: Howard S. Madigan, M.D., Medical College of Ohio, C. S. 10008, Toledo 43699, phone: 419/381-4237.

October 1977

BURN PATIENT: October 1; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

SELECTED TOPICS IN RHEUMATIC DISEASE: October 5-6; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

(continued on page 594)

Education Programs *(continued)*

DIAGNOSIS AND NON-SURGICAL TREATMENT OF GASTROINTESTINAL MALIGNANCIES: October 6; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

UPDATE ON PROBLEMS OF POISONINGS: October 6; Children's Hospital, Columbus; sponsor: Children's Hospital Medical Center of Akron; 7 credit hours; fee: $25, $10 (nurses, residents); contact: James V. Hillman, M.D., Children's Hospital Medical Center of Akron, Akron 44308, phone: 216/379-8449.

RECENT ADVANCES IN THE TREATMENT OF CANCER: October 12-13; Bunts Auditorium, Cleveland Clinic; contact: Penn G. Skillern, M.D., Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

MEDICAL ONCOLOGY SEMINAR: October 13; The Toledo Hospital, Toledo; 6 credit hours; fee: $15; contact: John B. Gibbs, M.D., The Toledo Hospital, Toledo 43606, phone: 419/473-4187.

CURRENT MANAGEMENT OF HEMOPHILIA: October 14; Biltmore Towers Hotel, Dayton; sponsor: Miami Valley Hospital; cosponsor: Wright State University School of Medicine Departments of Postgraduate Medicine and Pediatrics; 7 credit hours; fee: $25; contact: Arlene Polster, Programs Coordinator, WSU Department of Postgraduate Medicine, Dayton 45402, phone: 513/372-7140.

INTRODUCTION TO ELECTROPHYSIOLOGIC ASSESSMENT OF THE AUDITORY SYSTEM: October 14-15; Bunts Auditorium, Cleveland Clinic; 12 credit hours; fee: $150, $75 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

LASER APPLICATION IN DIABETES RETINOPATHY: October 15; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

RENAL AND UROLOGIC DISEASE IN CHILDREN: October 19; Cleveland Clinic Foundation; 4 credit hours; fee: $10; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

DOCTORS GRAND ROUNDS ("Headaches"): October 20; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, Community Medcenter Hospital, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301, ext. 292.

CURRENT THERAPY— VIII: October 21, 22, 23; Shawnee State Park Lodge, Portsmouth; sponsor: Scioto County Medical Society; cosponsor: American Academy of Family Physicians; 15 credit hours; fee: $40 (paid in advance), $50 (paid at time of course); meals: $50 per couple; contact: Lowell Thompson, Executive Secretary, Scioto County Medical Society, Portsmouth, phone: 614/354-5315.

SECOND ANNUAL ENDOCRINE SYMPOSIUM ("The Thyroid"): October 22; Sheraton Westgate Inn, Toledo; 8 credit hours; fee: $35; contact: Paul V. DeLameter, M.D., Mercy Hospital, Toledo 43624, phone: 419/243-8241, ext. 467.

BREAST CANCER— PRESENT-DAY APPROACH: October 26; Mt. Carmel Medical Center, Columbus; 3 credit hours; contact: William R. Hughes, Ph.D., Director of Education, Mount Carmel Medical Center, 793 West State Street, Columbus 43222, phone: 614/225-5178.

SIXTH ANNUAL MULTIDISCIPLINARY CARDIAC FORUM ("Pulmonary Heart Disease"): October 26; Kettering Medical Center, Kettering; sponsor: Wright State University School of Medicine; cosponsor: Kettering Medical Center, Miami Valley Heart Chapter, American Heart Association; 3 credit hours; contact: Mary Kothman, Kettering Medical Center, Kettering 45429, phone: 513/298-4331, ext. 278.

HEPATOBILIARY PHYSIOLOGY: October 27; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

PULMONARY DISORDERS: October 27; Batavia; 3½ credit hours; fee: $15; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

DIAGNOSTIC PROBLEMS IN JAUNDICE: October 28, NOON; Kettering Medical Center, Kettering; 1 credit hour; contact: Elvin C. Hedrick, M.D., Kettering Medical Center, 3535 Southern Boulevard, Kettering 45429, phone: 513/298-4331, ext. 278.

INFECTION AND ANTIBIOTICS IN ORTHOPEDICS SURGERY: October 29; Mount Carmel Medical Center Hospital Auditorium, Columbus; 3 credit hours; contact: William Hughes, Ph.D., Director of Education, Mount Carmel Medical Center, 793 West State Street, Columbus 43222, phone: 614/225-5000.

SEMINAR ON GASTROINTESTINAL DISEASE: October 30, 8:15 AM; Saint Anthony Hospital, Columbus; 6 credit hours; fee: $35; contact: Dale Nelson, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

November 1977

CLINICAL TOPICS IN PSYCHIATRY: First Tuesday, November and April, 8 AM; Dayton; sponsor: Neuropsychiatry Section of Montgomery County Medical Society; cosponsor: Miami Valley Hospital; 1 credit hour; contact: Alfred Hicks, II, M.D., Miami Valley Hospital, 1 Wyoming Street, Dayton 45409, phone: 513/223-6192.

CANCER AND CHEMOTHERAPY: November 1; Terrace Hilton Hotel, Cincinnati; sponsor: Cincinnati Oncology Society; cosponsor: Office of Continuing Medical Education, University of Cincinnati College of Medicine; 6¼ credit hours; fee: $35 physicians; $15 nurses and residents; contact: Office of CONMED, Dean's Suite E251, College of Medicine, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

GYNECOLOGICAL SURGERY: November 2-3; Cleveland Clinic Educational Foundation; 12 credit hours; fee: $100, $50 residents; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

PATIENT COMPLIANCE: November 4; Carrousel Inn, Cincinnati: 5 credit hours; fee: $15; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

OHIO STATE MEDICAL ASSOCIATION

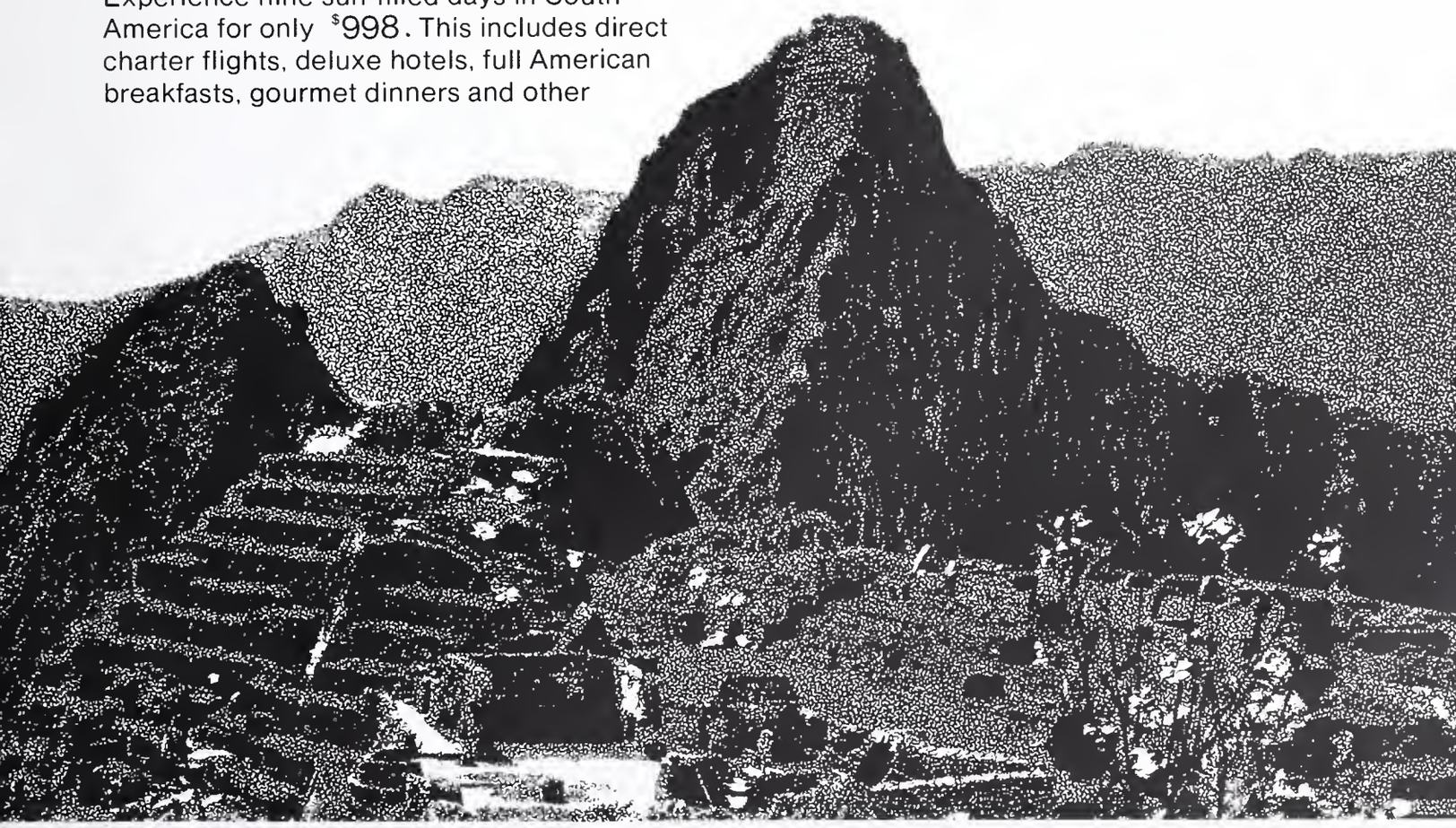
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 9, 1977 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present were: All members of the Council (with the exception of Drs. W. J. Lewis and Richard E. Hartle); Craig D. Barclay, representing James E. Pohlman, Esq., OSMA Legal Counsel; Dr. P. John Robechek, Cleveland, Chairman of the Ohio Delegation to the AMA; Dr. John H. Budd, Cleveland, President of the AMA; Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; David L. Rader, Columbus, Vice President/Administration, The Physicians Insurance Company of Ohio; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Mulgrew, Holcomb, Ayish, Torrens, Mrs. Wisse, Mrs. Dodson, Ms. Doll, Mrs. Jacobson, and Mrs. Franklin, of the OSMA Staff.

FUTURE MEETING DATES

Future dates for Council meetings were announced as follows: September 10, 1977; November 19, 1977; December 17-18, 1977; and February 11, 1978.

MINUTES

Minutes of the April 2, 1977 and the May 19, 1977 meetings of the Council **were approved.**

MEMBERSHIP

Membership statistics were presented by Mrs. Wisse.

The Council voted to invite into affiliate membership of the Ohio State Medical Association, in accordance with Chapter 1, Section 2(h) of the Bylaws, a number of state and county medical executives serving on a full-time basis.

FISCAL MATTERS

Dr. Rinderknecht presented the minutes of the July 8, 1977 meeting of the Committee on Auditing and Appropriations. He reported that Mr. Ben Minutilli of Coopers-Lybrand had reviewed the 1976 Audit with the Committee and that he complimented the Association and its Staff on the excellence of its system of fiscal reporting to the board of directors (The Council) and to the members of the Association.

This method involves listing of operating expenses in more detail with line items spread over the departmental structure and the Statement of Operations presented in departmental rather than descriptive terms so that the program budgeting and expenditures of the Association for a variety of its services may be readily ascertained.

Dr. Rinderknecht announced that the 1977 Budget was discussed with an analysis for the first six months of the year. The Council **approved** recommendations for several budget adjustments.

On recommendation of the Committee, the Council **approved** invoices totaling $39,753.78 for payment from the Malpractice Research Fund.

The Council **approved** expansion of computer usage to initiate financial record keeping and to further refine the membership system. A committee was appointed to proceed with the planning: Dr. Thomas, chairman; Dr. Diller and Dr. Ford.

The minutes of the July 8, 1977 meeting were accepted.

AMERICAN MEDICAL ASSOCIATION

A report on the Annual Convention of the American Medical Association, June 18-22, 1977, San Francisco, was presented by Dr. Robechek and by Dr. Budd. (See *The Journal,* Vol. 73, No. 8, August 1977, for complete details of the Convention.)

The Council voted to support Lawrence J McCormack, M.D., Cleveland, for appointment to the Residency Review Committee for Pathology of the AMA Council on Medical Education.

CONTINUING MEDICAL EDUCATION

Mrs. Dodson described plans for the May 6-10, 1978 Annual Meeting of the Ohio State Medical Association in Dayton.

OSMA HOUSE OF DELEGATES

The Council referred for implementation those resolutions which were adopted at the 1977 Annual Meeting of the Association. See Fig. 1. (Complete information on the resolutions appears in *The Journal,* Vol. 73, No. 7, July 1977.)

MEDICAL ADVANCES INSTITUTE

The Council recessed and was convened in a closed session to discuss Medical Advances Institute.

The closed session was adjourned; and the Council was reconvened, at which time it was voted to decline the opportunity to cosign a note for a $75,000 loan requested by Medical Advances Institute.

OHIO MEDICAL INDEMNITY, INC.

Dr. Dorner and Mr. Gillen reported on recent Ohio Medical Indemnity, Inc. board meetings.

PHYSICIANS INSURANCE COMPANY OF OHIO

David L. Rader, Vice President/Administration, Physicians Insurance Company of Ohio, presented the Company's June 1, 1977 offering circular and reported on the $1 million excess coverage now being offered by the Company.

(Proceedings continued on page 598)

ACTION ON RESOLUTIONS
ADOPTED AT 1977 OSMA ANNUAL MEETING

Resolution	Subject	Referred to
Am. Res 2-77	OSMA Committee Appointment Procedures	Print in Bylaws
Am. Res. 3-77	House Officers Section	Ad Hoc Committee
Am. Res. 5-77	Special Meetings	Print in Bylaws
Am. Sub. Res. 8-77	Unified Membership	Ad Hoc Committee
Am. Sub. Res. 14-77	Relative Value Schedules	Dept. of Federal Legislation
Am. Sub. Res. 15-77	HEW Provider Agreement	AMA/Dept. of Federal Legislation/ Comm. on Government Medical Care Programs
Am. Sub. Res. 22-77	Title 19 (Medicaid)	AMA/ Comm. on Government Medical Care Programs
Am. Sub. Res. 23-77	Cost Containment/ Government Health Programs	Letter to insurance carriers and government third-party programs
Am. Res. 28-77	Advertising Ethics	Comm. on Judicial and Professional Relations
Res. 29-77	Uniform State Health Agency Forms	Notify insurance carriers and government third-party programs
Am. Sub. Res. 30-77	Liability Reform	Task Force on Professional Liability/ State Legislation Dept.
Res. 32-77	Umbrella	Task Force on Professional Liability/ State Legislation Dept.
Res. 33-77	Sliding Scale	Task Force on Professional Liability/ State Legislation Dept.
Am. Res. 34-77	Contingency Fees	Task Force on Professional Liability/ State Legislation Dept.
Res. 36-77	Impartial Arbitration	Task Force on Professional Liability/ State Legislation Dept.
Res. 37-77	Occurrence Contract From JUA	Task Force on Professional Liability/ State Legislation Dept.
Res. 42-77	Statute of Limitations	Task Force on Professional Liability
Res. 48-77	Commendation for Task Force on Professional Liability	Notify Task Force
Res. 49-77	Information Requested on Physician's Application for Hospital Privileges	Council and Legal Counsel
Am. Res. 56-77	County Society-PICO Relationships	PICO with follow-up by Task Force on Professional Liability
Am. Res. 58-77	Optometry	Dept. of State Legislation/Comm. on Eye Care
Am. Sub. Res. 59-77	Laetrile	Dept. of State Legislation/Comm. on Cancer
Am. Res. 62-77	Opposition of Repeal of Drug Anti-Substitution Act	Comm. on State Legislation/Comm. on Private Practice and Patient Care
Am. Sub. Res. 65-77	Repeal of Am. HB 1000	Dept. of State Legislation
Res. 66-77	Reaffirmation of Res. 45-66	AMA House of Delegates
Sub. Res. 67-77	Protecting Consumer Against Inadequately Trained Physicians	AMA Delegation/ Comm. on Education/ Commission on Medical Education
Res. 68-77	Legal Defense Fund	Council
Sub. Res. 75-77	Alterations of Hospital Discharge Summaries	AMA
Sub. Res. 78-77	News Presentations on Socio-economics of Medicine	Dept. of Communications
Am. Sub. Res. 79-77	Alcoholism Insurance Coverage	Comm. on Mental Health
Res. 80-77	Physician Effectiveness Programs	Comm. on Mental Health
Sub. Res. 82-77	Ohio State Medical Board	Dept. of State Legislation
Res. 85-77	In Memoriam to Steven Kovacs, M.D.	Notify Mrs. Kovacs
Res. 87-77	JCAH Standards	Council/Comm. on Government Medical Care Programs/AMA Delegation

(Proceedings continued on page 600)

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Proceedings *(continued)*

COMMITTEE REPORTS

Mental Health

The minutes of the April 17, 1977 meeting of the Committee on Mental Health were presented by Mr. Clinger and were accepted.

Joint Advisory Committee on Sports Medicine

The minutes of the May 17, 1977 meeting of the Joint Advisory Committee on Sports Medicine were presented by Mr. Clinger and were accepted.

Private Practice and Patient Care

The minutes of the May 25, 1977 meeting of the Committee on Private Practice and Patient Care were presented by Mr. Edgar.

A committee recommendation for an education campaign on proper narcotic drug prescribing practices and the Drug Enforcement Administration regulations **was approved** by the Council along with the suggestion that the OSMA Continuing Medical Education programs include material on this subject.

It was suggested that the Ohio Department of Welfare be asked for specifics with regard to the names of physicians who by their prescribing practices appear to be abusing the Medicaid program.

The International Rehabilitation Associates program was discussed in relation to the report of the Committee.

Two recommendations of the Committee **were approved:** One, that OSMA address a formal letter to IRA strongly requesting that IRA first contact the physician in charge of the care and obtain his consent before contacting the patient; and two, that the IRA operation be referred to legal counsel for review as to its potential for causing malpractice litigation.

Action on two other suggestions was deferred by the Council.

The report was accepted as amended.

Family Practice Scholarships

A report of the Committee meeting June 15, 1977 was presented by Mr. Clinger, including an announcement of 1977 scholarship recipients.

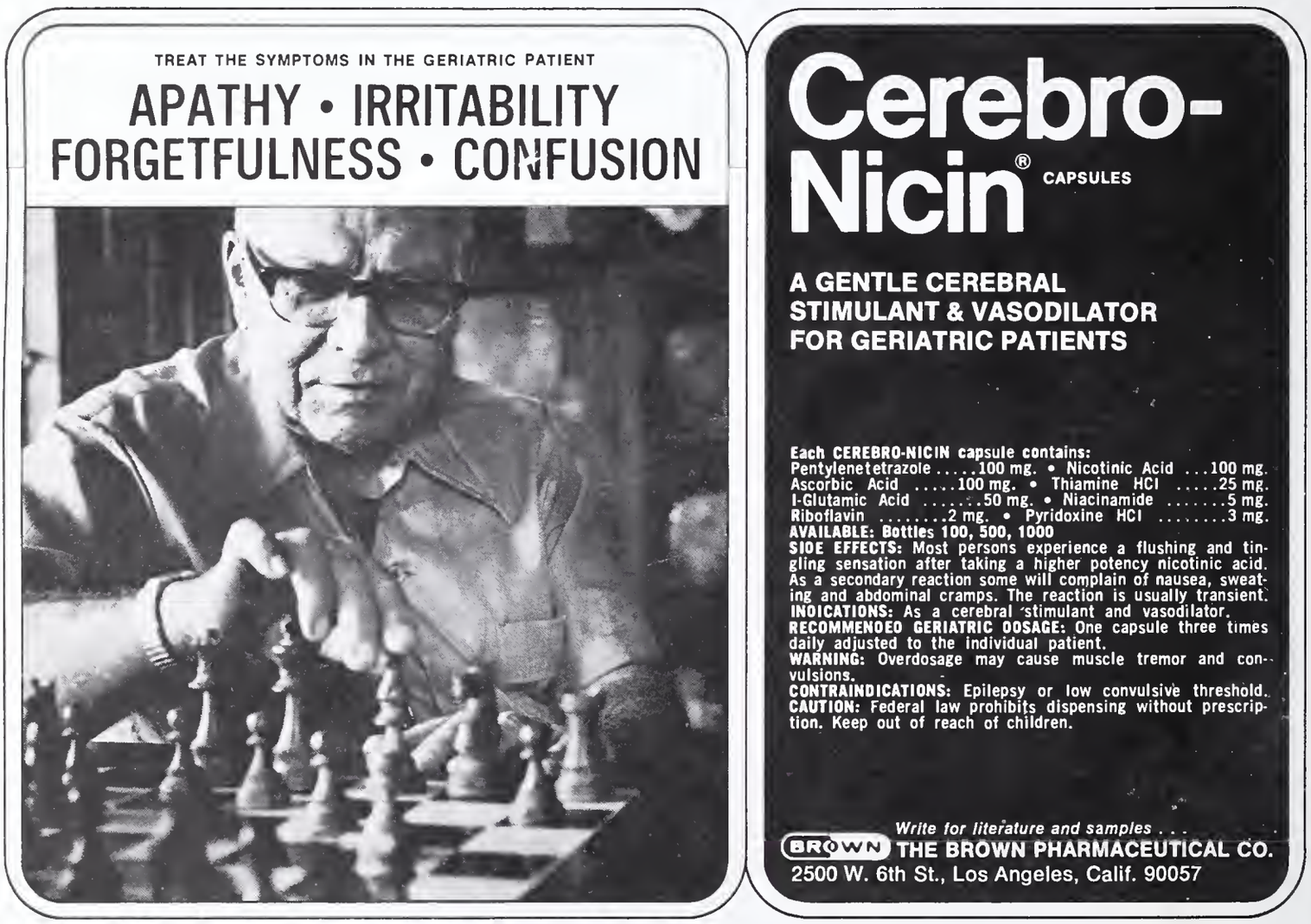
A recommendation from the Committee that the amount of the scholarships be increased was referred to the Committee on Auditing and Appropriations for consideration when the 1978 budget is prepared.

Education

The minutes of the June 30, 1977 meeting of the Committee on Education were presented by Mrs. Dodson.

The Council studied the recommendations of the Liaison Committee on Continuing Medical Education (LCCME) of the AMA with regard to medical education programs of State Medical Associations.

The Council voted to restructure the Committee on



Education along lines recommended by the LCCME and to discontinue the Commission on Medical Education of the OSMA.

Maternal and Neonatal Health

The minutes of the March 27, 1977 meeting of the Committee on Maternal and Neonatal Health were presented by Mrs. Dodson and **were approved.**

Mr. Torrens reported on the OSMA workshop for resident physicians, "Establishing Yourself in Medical Practice," held April 12 and 13, 1977 at OSMA Headquarters. He announced a similar workshop is to be held March 14-15, 1978.

FEDERAL LEGISLATION

Mr. Edgar reported on successful efforts to obtain corrective amendments to H.R. 3816.

Mr. Edgar discussed the campaign to obtain Ohio congressional supporters for AMA's H.R. 1818.

He analyzed H.R. 3, the Administration's bill to nationalize health care. The Council voted active opposition to H.R. 3.

The Council voted support to an amendment submitted by Medical Advances Institute which would continue federal support of state "support centers" developing peer review programs.

The concept of a "cap" on hospital benefit payments under federal programs was opposed.

The Council voted to oppose in principle the Hospital Cost Containment Act of 1977 (H.R. 6575 - S. 1391).

STATE LEGISLATION

Mr. Mulgrew reported on state legislation, commending Mr. Ayish for his outstanding work in achieving the OSMA success with the Laetrile bill.

Mr. Ayish reported the generic substitution bill had passed both Houses with the consumer "pass through" amendment in tact. This amendment requires pharamacists to pass through any savings achieved through substitution to the consumer.

Mr. Mulgrew's testimony, July 6, 1977, before the Ohio State Board of Chiropractic Examiners, objecting to the board's proposed rules expanding the scope of chiropractic practice was reviewed. Mr. Mulgrew reported the Board has decided to withdraw its proposed rules.

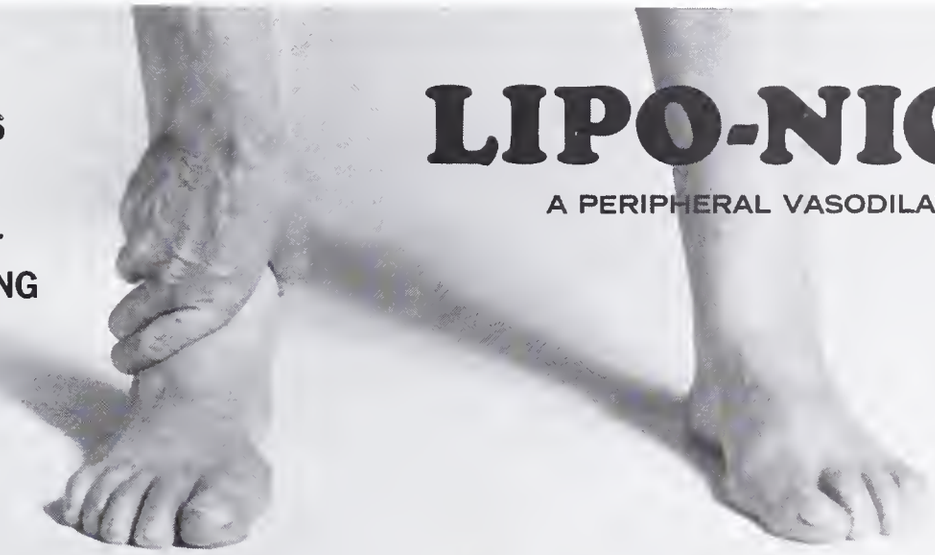
A complete report on the status of all bills that concern medicine was given.

The Council voted to take "no position" on the present version of H.B. 209, the physical therapy bill, which has been amended considerably, in line with most OSMA recommendations.

The Council voted to support H.B. 162, a bill per-

(Proceedings continued on page 602)

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Each blue tablet contains:
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Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

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LIPO-NICIN/300 mg.
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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mitting motorcycle driver education.

H.B. 710, regarding family life education, was referred to the OSMA State Legislative Committee.

H.B. 282, a bill requiring that schools keep immunization records, received the support of the Council.

JUA

Mr. Campbell presented current statistical information regarding the JUA (Joint Underwriting Association).

CONSTITUTION AND BYLAWS

Amendments to the Constitution and Bylaws of the Marion County Academy of Medicine **were approved.**

Amendments to the Constitution and Bylaws of the Shelby County Medical Society **were approved,** with the exception of a proposed Article III of the Constitution.

LEGAL COUNSEL

The Council referred to legal counsel the question as to whether the rejection of Resolution 77-77 by the OSMA House of Delegates constitutes a change in policy regarding "contraceptive services for minors."

OHIO STATE MEDICAL JOURNAL

Mrs. Jacobson presented the report of the *Ohio State Medical Journal.* The Council **approved** an increase in advertising rates.

PUBLIC RELATIONS

Ms. Doll reported on implementation of the Blackwell-Talarzyk report recommendations and announced a Public Relations Conference for County Medical Societies, to be held October 15-16, 1977.

DIRECTOR OF HEALTH

Dr. Ackerman addressed the Council concerning legislation which, if passed, would remove health planning from the Department of Health, and a bill which would transfer the alcoholism program from the Health Department to the Department of Mental Health and Mental Retardation.

He discussed the probability of state legislation on the subject of laboratory licensing. This matter was referred to the Committee on Laboratory Medicine.

COMMITTEES APPROVED

Standing and Special Committees appointed by Dr. Wells were ratified by the Council.

SCHOOL MEDICAL PROCEDURES CHART ENDORSED

A chart for school medical procedures developed by the Butler County (Ohio) Board of Education, having been previously endorsed by the Butler County Medical Society, received the endorsement of the Council.

ATTEST: Hart F. Page
Executive Director



Cardilate® (erythrityl tetranitrate)
INDICATIONS. For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS. As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

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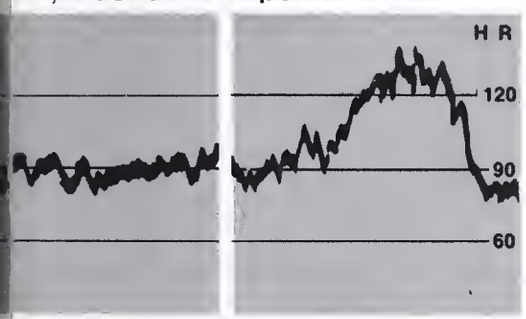
"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

Sex and the heart patient:

A film every doctor should see.

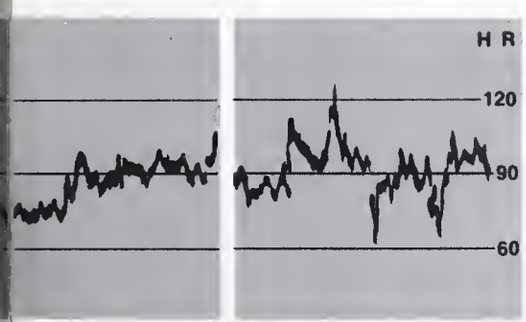
The energy cost of sex to the heart is relatively modest.
Over 80% of post-coronary patients can ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extra-marital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



A. Working in office (about 90 beats/min)

B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)

D. Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex
In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

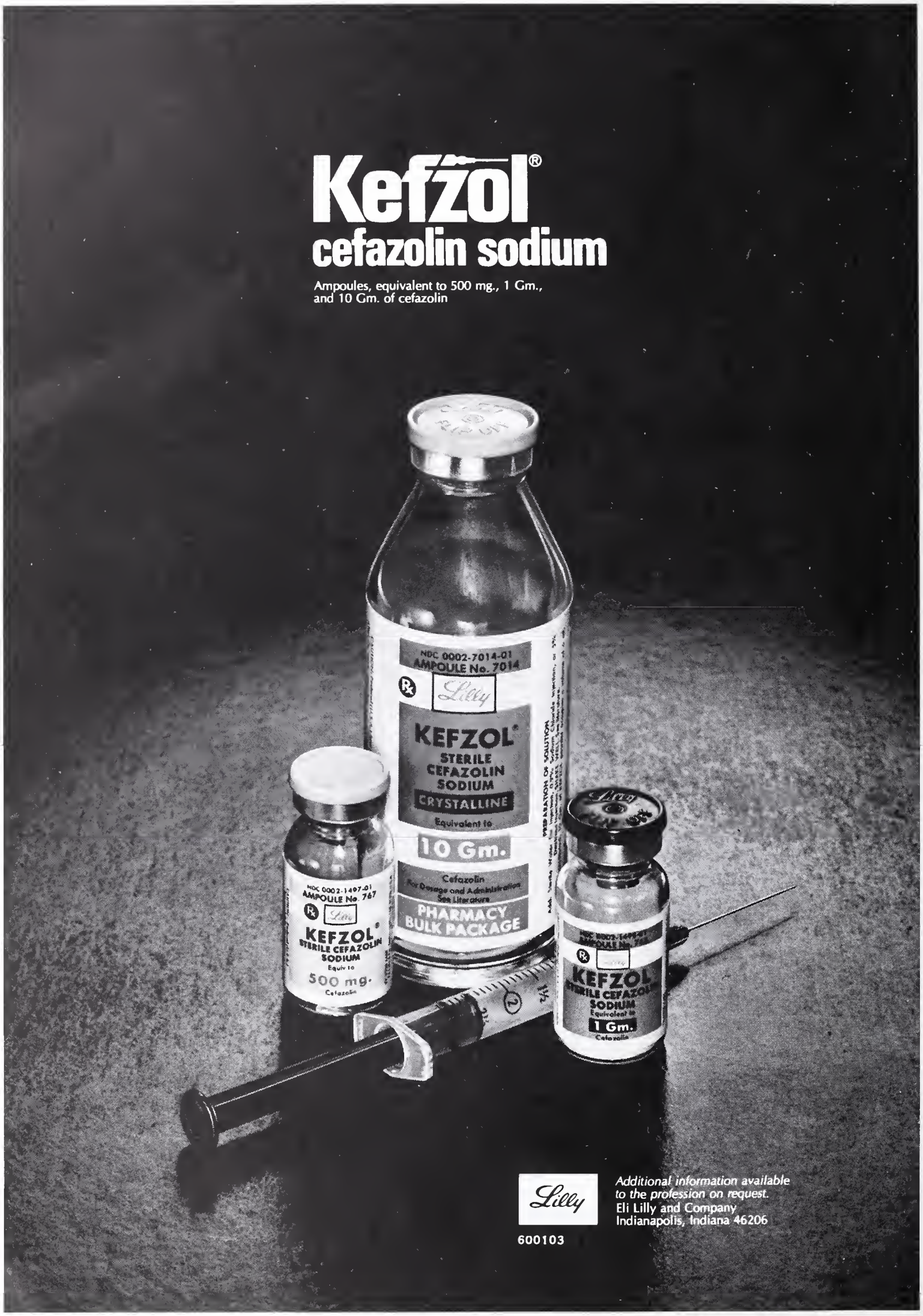
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Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.
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THE OHIO STATE Medical Association Clinical and Scientific

Role of Radiation Therapy in Bronchogenic Carcinoma

Wagih M. Shehata, M.D.

A total of 375 patients with lung cancer who were treated by radiation therapy over a five-year periad were evaluated. Of the total, 47 percent had undergone thoracotamy, and 21 percent had previously had surgical resectian of the primary cancer. Although 52 percent of the carcinomas were classified as stage IIIA and 38 percent as stage IIIB, one- and three-year survivals were 35 percent and 12 percent, respectively. Five-year survival following radiation occurred in some early cases and even occasionally with stage III disease.

Careful research for metastasis helped to select the cases for attempts at radical therapeutic radiation, avoiding undue morbidity to stage IIIB cases. Palliation by radiation was quite satisfactory when it was administered to primary or secondary lesions. Avenues for improving the grim outlook for this type of carcinoma are discussed.

CARCINOMA OF THE LUNG is the most common type of cancer found in men;[1] its incidence has increased 125 percent over the past 25 years.[2] This represents a decided increase in incidence which has been demonstrated in Great Britain.[3] Radiation therapy is used in more than 50 percent of the cases.[4] Lately, 23 percent of the cancer patients referred to our radiotherapy department had the diagnosis of bronchogenic carcinoma. In spite of its prevalence, only about 5 percent of these patients survive five years with a median survival of six to nine months.[5]

Methods and Materials

Over a five-year period (1969-1973), a total of 375 patients with carcinoma of the lung were evaluated after treatment by the Radiation Department of the Hinsdale Sanitarium and Hospital, Hinsdale, Illinois. Of these, 22 percent were female; 71 percent were in the age group from 50 to 70 years. The youngest patient was a 1-year-old infant who died of undifferentiated carcinoma, and the oldest was an 86-year-old man. Only 6 percent of these were nonsmokers. A total of 23 patients (5.8 percent) had a second primary cancer.

Evaluation

Evaluation included investigations for proof of diagnosis, staging, search for metastasis, and general medical evaluation including:

1. Careful history and physical examination, palpation for lymphadenopathy, examination for vocal cord mobility, and neurologic evaluations should be considered in all cases.

2. Chest roentgenogram,[6,7] tomograms whenever incated,[8] and occasionally, bronchography[9] and angiography.[10] A suspected nipple shadow shown on a routine chest roentgenogram should be evaluated carefully with appropriate radiologic views.

3. Sputum cytology, bronchoscopy — with or without brushing, scalene node biopsy, mediastinoscopy, needle biopsy, or possibly thoracotomy were used when indicated.

Table 1 describes the methods by which final diagnosis was reached. A total of 47 percent of all patients had undergone thoracotomy, and 21 percent had had surgical resection previously (13 percent had lobectomy and 8 percent had pneumonectomy). The criteria for inoperable cases were extension to the mediastinal structures, scalene or axillary lymph node metastasis, malignant pleural effusion, or poor medical status. A total of 5 percent of the

Dr. Shehata, Cincinnati, Director, Radiation Oncology, Good Samaritan Hospital. At the time this study was made, he was Chief Radiotherapist, Hinsdale Sanitarium and Hospital, Hinsdale, Ill.; and Assistant Professor of Radiotherapy, Rush Presbyterian-St. Luke's Medical Center, Chicago.

Reprint requests to Department of Radiation, Good Samaritan Hospital, Cincinnati, Ohio 45220 (Dr. Shehata).

Submitted November 15, 1976.

patients were treated for superior vena caval obstruction for palliation.

4. Pulmonary function tests and lung scans.[11-13] Figure 1 shows the value of lung scan in one patient. Absent perfusion in one lung field could be associated with an almost-normal-looking chest x-ray film. Invariably, this means gross mediastinal disease which is inoperable. Return of perfusion can result from relief of obstruction by radiotherapy.

5. Gallium 67 scan. This is useful for detecting mediastinal metastasis (usually an indication that the lesion is inoperable) and distant metastasis. A negative result of scan does not exclude the presence of primary or metastatic disease. However, it is fairly reliable in positive cases although it is not specific at times and could be confused with pneumonia or empyema.[14,15]

6. Liver chemistry, liver scan, and bone scan were quite helpful in detecting early distant metastasis even in the absence of signs and symptoms. Liver and bone scans were performed in one-third of the total cases. A total of 25 percent of the patients who had undergone lobectomy and 11 percent of those who had undergone pneumonectomy were found to have distant metastasis at the time they were evaluated in the radiotherapy department. In our experience, a routine brain scan was not helpful in the absence of symptoms and signs. These screening tests to detect distant spread helped to reduce morbidity and to save money for patients treated palliatively by reducing the total dosage and number of treatments required. They also served as a baseline study for future references.

Table 2 describes the histologic types and average survival in each group. Both squamous cell and adenocarcinoma patients survived about the same length of time although the patients having the well-differentiated forms

TABLE 1. Methods by Which Final Diagnosis Was Reached

	No. of Patients	%
X-ray, clinically (not proved histologically)	11	3
Pap smear only, classes 4 and 5 (one from pleural effusion)	30	8
Bronschoscopy washings and smears	79	21
Scalene node biopsy alone	41	11
Thoracotomy and needle biopsy of which 11 percent is by needle (two cases bone biopsy from metastasis)	214	57
Total	375	100

TABLE 2. Histologic Types and Average Survival in Each Group

Type of Carcinoma*	No. of Patients	%	Average Mean Survival (Months)
Poorly differentiated squamous cell, classes 3 and 4	155	41.3	10.8
Fairly differentiated squamous cell, classes 1 and 2	79	21.1	12.0
Oat cell (small cell)	38	10.1	10.7
Well differentiated adeno, classes 1 and 2	31	8.3	12.9
Poorly differentiated adeno, classes 3 and 4	19	5.1	11.5
Large cell	18	4.8	9.0
Unknown	19	5.0	9.0
Mesothelioma	7	1.9	6.3
Alveolar cell type	3	0.8	2.0
Carcinoid	3	0.8	10.0
Teratoma	3	0.8	3.0
Total	375	100.0	

*60% of total cases were undifferentiated histological types.



FIG. 1. Patient: 54-year-old man with squamous cell carcinoma, right main stem bronchus, stage IIIA, considered inoperable. Lung scan before radiation therapy (left); chest roentgenogram before starting therapy (center); and lung scan at completion of radiation therapy of 1,839 ret. Patient improved with return of perfusion to right lung, lived symptom free, died six months later with fatal hemoptysis. No autopsy.

of carcinoma survived slightly longer than those with the undifferentiated varieties.[16] In our experience, adenocarcinoma had almost the same radiation response rate as squamous cell cancer. The site of primary origin did not correlate with survival.

Staging.[17,18] The staging system used was adopted with slight modification (stage IIIB for distant metastasis) from the American Joint Committee Staging System (AJCSS),[5] as shown in Table 3. A total of 26 percent of stages I, II, and IIIA patients showed evidence of metastasis in the first three months and 20 percent in the second three months, however, 47 percent of the lesions remained localized (29 percent of the total group).

Techniques of Therapy

Of the total group, 43 percent failed to show extra thoracic spread and were considered potentially curable with supervoltage therapy. Recommended treatment dosage was 1,600 to 1,700 ret* in about six weeks with occasional use of split course. When possible, patients with spread to the mediastinum were treated with the intent to cure. The mediastinum was covered in 95 percent of the cases. The ipsilateral supraclavicular fossa is covered for upper lobe lesions and bilaterally for undifferentiated histology. Port for the initial treatment covered the gross disease plus a 2- to 3-cm safety margin. Subsequently, treatment was continued by reduced field after 1,200 to 1,400 ret avoiding critical organs (eg, spinal cord) using a plan of multiple ports or arcing. Appropriate lung correction was considered for peripheral lesions. Patients were treated five times per week with a daily tumor dose of 200 rads.

A total of 41 percent of the patients needed palliation to the primary lesion because of the presence of symptoms or impending compression. These patients had a median survival of six months with 18 percent surviving one year. They received 900 to 1,200 ret in three to four weeks. Ten patients received short fractionation technique of similar nominal standard dose equivalent (NSDE),[19] by 3 to 15 fractions with no significant difference in the response or survival as compared to those who received conventional fractionation. Short fractionation seemed advantageous to patients with short survival.[20] Palliation generally was effective in controlling the primary lesion. The majority of these patients died from slow, general deterioration without significant chest symptoms. The two patients with extensive disease who were treated with whole lung irradiation on one side for a total of 1,100 ret survived 4 and 12 months, respectively. Colloidal radioactive phosphorus (P32), 15 to 20 millicurie, was helpful in controlling pleural effusion. In eight cases, the distribution of the radioactive material was assessed by lung scanning using the beta radiation emitted from P32.

In only seven patients, a preoperative course of radiation[21] was given in doses of about 1,300 ret, with an average survival of 21 months. Paulson[22] reported improved survival rate of superior sulcus tumor patients treated by preoperative irradiation, however, the number of patients was relatively small.[7,23]

In 16 percent of the total group, metastatic lesions were treated without the need to treat the primary tumor for palliation. Palliation of bony lesions was achieved in 80 percent of the cases using short fractionation schedules. Twenty percent of irradiation to the brain for metastasis was given by short fractionation technic in two-to-three, daily consecutive treatments for 1,000 to 1,200 ret, with an 80-percent improvement rate.

Complications

No patient developed radiation myelitis or became a pulmonary cripple because of radiation therapy. One patient had severe esophagitis that improved in three months. Only 9 percent of the patients showed worsening of their pulmonary capacity after therapy; most had local extensive disease. A total of 16 percent had poor tolerance to the therapy in the form of esophagitis, pneumonitis, and heart failure. Of the patients receiving palliation to the primary lesion, 20 percent died during their course of therapy or shortly after. One patient, a 61-year-old man with squamous cell carcinoma, right main stem bronchus, died two years after therapy (1,750 ret) from hemorrhagic pericarditis. No evidence of local disease or metastasis was found at autopsy.

Chemotherapy[24] was given in 22 percent of the cases, the majority for stage III carcinoma. The most frequently used agents were nitrogen mustard and cyclophosphamide. There was no significant improvement in survival for those who received chemotherapy, however, this was not a study made at random.

Survival

Table 4 cites the survival rates according to stage, while Table 5 shows the total actuarial survival rates. Even though the numbers in stages I and II are small, the survival rate definitely was better than in stage III. About half of the stages I and II patients were treated by radiation therapy alone. Of 67 stage IIIA cases, 12 survived three years; possibly some of these are cured. (See Figure 2.)

Table 6 describes the response to radiotherapy as evaluated by chest roentgenogram. Of those cases treated with a curative intent, 52 percent had documented or probable local recurrences (evidenced by x-ray film of the chest or tomography) in the treated area. They had a median survival of ten months.

Discussion

In this series, 94 percent of the smokers group had stopped smoking either at or prior to the time of diagnosis.

*Equivalent to approximately 6,000 rads.

Table 3. Staging System Use[5]

T:	Primary tumor	N:	Nodal disease	M:	Distant metastasis
T_1:	A tumor is 3 cm. or less in its greatest diameter surrounded by lung, without evidence of invasion proximal to lobar bronchus at bronchoscopy	N_0:	No demonstrable metastasis in regional lymph nodes	M_0:	No distant metastasis
T_2:	A tumor more than 3 cm. or extend to hilar region but not distal to carina by 2 cm. at bronchoscopy, no pleural effusion	N_1:	Metastasis to lymph nodes in ipsilateral hilar region	M_1:	Distant metastasis including scalene, cervical axillary or contralateral hilar nodes, brain, bone, lung, liver
T_3:	Any size tumor with extension to chest wall, diaphragm, mediastinum or within 2 cm. from carina	N_2:	Metastasis to lymph nodes in mediastinum		
Stage I:	$T_1N_0M_0$ $T_1N_1M_0$ $T_2N_0M_0$	Stage II:	$T_2N_1M_0$		
Stage IIIA:	T_3 with any N, M_0 N_2 with any T, M_0	Stage IIIB:	M with any T or N (Distant metastasis)		

At the present time, there is overwhelming evidence incriminating cigarette smoking to the etiology of this disease (Surgeon General of U. S. Report of 1964,[25] Royal College of Physicians 1971,[26] also correlated with data collection in Switzerland by Abelin in 1965[27]). In fact, our best weapon available now is prevention of smoking.[28] This could be achieved by an intensive, educational campaign against smoking or possibly by strong, restrictive, legislative action. Other factors of less importance are air pollution, coal tar, asbestos, radioactive ores and atomic radiation, bronchitis, bronchiolitis, and chronic pneumonitis.[3,18,28-31] Four percent of the total group gave a definite history of chronic exposure to industrial fumes. Previous serious medical problems were present in 23 percent; 30 percent of these were cardiac and 16 percent were peptic ulcers, probably related to smoking. A history of previous or associated pulmonary conditions was present in 13 percent, 10 percent of which was tuberculosis.[32]

It is to be noted that 59 percent of the total group had evidence of hilar lymphadenopathy (by x-ray evidence or exploration), while 50 percent had lymphadenopathy in the mediastinum. Of the total group, result of scalene lymph node biopsy was positive in 13 percent (70 percent on the right side); 2.3 percent had a positive result from axillary node biopsy (67 percent on the right). None of these cases (positive scalene or axillary lymphadenopathy) could be cured by any modality even with aggressive approach. Also, cure was not possible for recurrence after surgery or radiation although local control could be achieved.[33]

Although about 50 percent of the patients had local recurrences or persistent disease after radiation, 80 percent of these presented with local recurrences as part of general dissemination of the disease prior to death.

Autopsy was performed on 10 percent of the total group; metastasis was found in practically every organ, the majority in the bones, liver, lymph nodes, and the other lung, respectively.

Although five-year survival following radiation is possible in many cases,[24,34] it should not be a substitute for an attempt at effective surgery since surgery offers the advantages of obtaining a tissue diagnosis and careful evaluation of the extent of the disease. (See Figure 3.) If the lesion has been resected adequately, the risks of high-dose radiotherapy will be minimized. The number of patients surviving four or five years is too small statistically to draw any definite conclusions. Of the four patients who survived five years, two were treated postoperatively

Table 4. Survival According to Stage

Stage	Total No. of Cases	Total No. %	1st-Year Survival No.	%	3-Year Survival No.	%	5-Year Survival No.	%
I	7	1.8	5/7	71	2/3	66	0/0	0
II	30	8.0	19/30	63	5/12	41	2/6	33
IIIA	196	52.2	79/196	40	12/67	18	2/17	12
IIIB	142	38.0	28/142	19	0/74	0	0/16	0

TABLE 5. Actuarial Survival of Total Group*

Years	No.	%
5	4/39	10
4	14/131	11
3	19/156	12
2	33/206	16
1	131/375	35

*No correction for death from natural causes.

TABLE 6. Response to Radiotherapy Evaluated by Chest Roentgenogram Three Months After Therapy

Change		%
None seen at beginning		18
No response		15
Fair (25% objective regression)	35	
Good (75% objective regression)	19	
Ablation (no tumor left)	13	
		67

for stage IIIA disease, one underwent pneumonectomy, and the other had a lobectomy. The third patient was treated by preoperative radiation followed by lobectomy; the fourth patient was treated by irradiation alone for stage I disease. In 39 patients (10 percent of the original group), there was no evidence of disease, with a median survival of 28.5 months; 67 percent of these have lived for two years and 27 percent survived four years. Of this group, 42 percent had previous surgical resection (62 percent for lobectomy and 38 percent for pneumonectomy). Forty-six percent had received 1,700 ret and another 46 percent had received 1,400 to 1,700 ret. In retrospect, 76 percent of those treated with an intent of cure did not survive, with a median survival of 10.6 months, 64 percent of whom had received doses of 1,700 ret and 20 percent who received 1,600 to 1,700 ret. In general, there was no statistical difference in survival for those treated by lobectomy versus pneumonectomy. Both groups had an average survival of 17 months.

Johnson and Walter[35] evaluated 100 patients with inoperable carcinoma of the lung treated by short fractionation technique in which 30 percent survived one year and 6 percent survived five years. This is almost comparable to our results. Short fractionation might improve oxygenation, delay onset of metastasis, and possibly improve immunity.[35] Further study is needed and possibly could be used for cases of curative intent. Since the majority of failures are due to distant metastasis, further chemotherapeutic trials[24] are needed to control microscopic disease before the onset of distant metastasis. From this data, one concludes that five-year survival following radiation is possible even in stage IIIA disease. Such cases



FIG 2. Chest roentgenogram of 67-year-old man with undifferentiated squamous cell carcinoma, left upper lung, with positive mediastinal nodes, attached to chest wall and inoperable following thoracotomy. Before therapy (left), and after 1,750 ret of Cobalt 60 (right). Last seen free of disease 4½ years after therapy.

could not be saved if a pessimistic approach to the problem were considered using palliative dose levels. This would emphasize the need for careful search for distant metastasis before a "cure-versus-palliation" decision is made. Currently, we advise repeat bone and liver scans by the fourth week of radiation therapy since, in many instances, the case will be stage IIIB and in that case, radiation therapy will be discontinued at the palliative level.

Conclusions

It is important to screen patients for evidence of distant metastasis before administering definitive therapy that should be adequate in volume and dose. Radiation is quite effective in controlling primary and secondary lesions of bronchogenic carcinoma. It could provide a five-year survival in selective cases. Continuing effort should be made to improve clinical trials and to search for better chemotherapeutic management or immunotherapy,[36] along with other modalities for optimal response.

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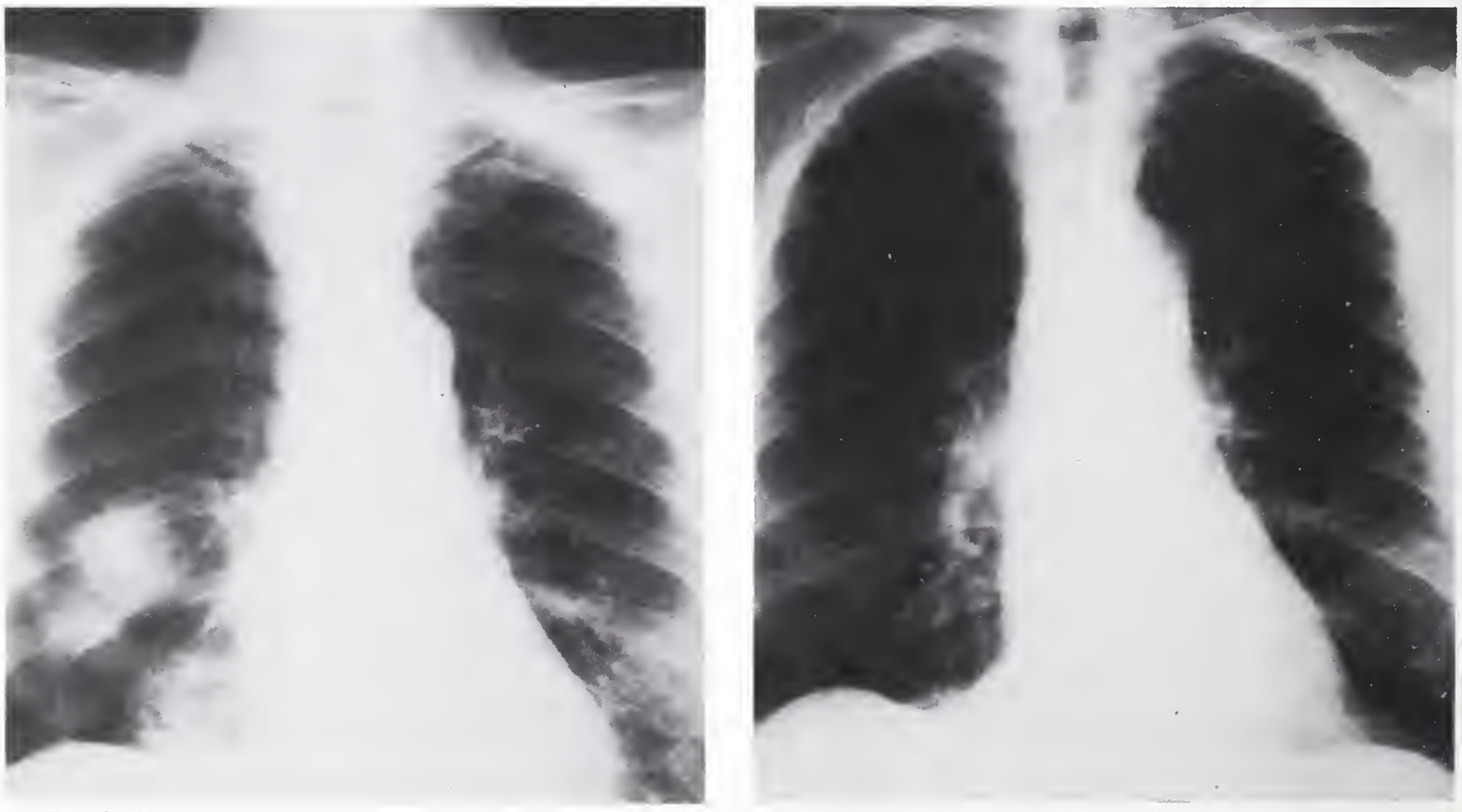


FIG. 3. Chest roentgenogram of 68-year-old man with squamus cell carcinoma, right lung, confirmed by needle biopsy as stage I possibly stage II. Was inoperable because of multiple, chronic medical problems. Before radiotherapy (left), and after 1,600 ret of supervoltage therapy (right). No evidence of disease two years after therapy.

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Mucocutaneous Lymph Node Syndrome

Bruce L. Hammond

Mucocutaneous lymph node syndrome (MLNS), sometimes called Kawasaki disease, is an illness of infancy and childhood whose principal features are fever, conjunctivitis, fissuring of the lips, strawberry tongue, reddening of the oral cavity, polymorphous exanthem of the trunk, cervical adenitis, and a fiery-red rash of the palms and sole with indurative edema of the hands and feet progressing to desquamation. There often is evidence of carditis, and 1 to 2 percent of the children die of acute myocardial infarction secondary to coronary vasculitis. The etiology is undetermined but infectious or toxic agents or allergy have been considered. There is a clinical and pathologic resemblance to infantile periarteritis nodosa, especially in those children who have died of MLNS.

IN 1967, KAWASAKI described 50 cases of an illness which had been afflicting infants and children in Japan since the early 1960s.[1] He termed the illness mucocutaneous lymph node syndrome (MLNS), and the clinical entity subsequently has been identified in over 6,000 Japanese children.[2] His studies were conducted during the period of 1961 through 1966, with the patients ranging in age from 2 months to 9 years although more than half were under 2 years of age. Cases with clinical findings indistinguishable from MLNS have been reported from Korea, Greece, Canada, Hawaii, and the continental United States although the incidence and recognition of MLNS in countries other than Japan is unknown at this time.[3]

Clinical Manifestations

Numerous case reports have appeared in the literature,[4-6] and these may serve to illustrate the clinical presentation of the syndrome. The typical clinical course begins with hectic fever in the range of 37.8 C (100 F) to 40.6 C (105F) which does not respond to antibiotic therapy, bilateral congestion of the bulbar conjunctiva, diffuse erythema of the oral cavity, prominence of the tongue papillae (strawberry tongue), and tender, nonpurulent cervical adenopathy. The lips usually are dry and hyperemic and may have fissures or erosions. The hands and feet become indurated and edematous, and the palms and soles develop a diffuse, fiery-red rash that persists for about ten days. Within five days after the onset of fever, a macular, erythematous rash may be found over the trunk, neck, face, extremities, and genitalia. This eruption may be multiform with macules and papules, morbilliform, or scarlatiniform but there are no vesicles or crusts.[7] From the 10th to 14th day after onset of the illness, the fever and exanthem begin to subside and membraneous desquamation begins on the fingers and toes in the subungual or periungual regions. Other findings may include mild jaundice, diarrhea, proteinuria or pyuria, arthralgia or arthritis, and evidence of carditis — tachycardia, gallop rhythm, distant heart sounds, heart murmurs, and EKG changes.[8] Laboratory findings include leukocytosis with left shift, slight anemia, thrombocytosis, increased erythrocyte sedimentation rate, positive C-reactive protein, increased α_2-globulin, and negative antistreptolysin O (ASO) titer. Rarely, there is a slight increase in the serum transaminases.[1]

A special MLNS study group, established in Japan in 1970, registered 6,537 cases (5,524 definite and 1,013 probable) with 111 deaths (1.7 percent). The male incidence was found to be greater than that in females (1.5:1), with the greatest incidence in 1-year-olds and in 80 percent of the patients younger than 4 years old. There was a slight increase in numbers reported from May to July.[1,2]

Despite its protean manifestations, the majority of children affected with MLNS appear to recover completely. There is a 1 to 2 percent mortality rate with sudden death usually occurring during the third or fourth week of illness. Those at greatest risk appear to be the boys less than 1 year of age with highly elevated sedimentation rate and prolonged, recurrent fever and rash.[7] In the majority of cases, sudden death has been due to acute heart failure secondary to myocardial infarction. At autopsy, there frequently is evidence of a vasculitis of the coronary arteries. Abnormalities such as aneurysmal dilatation, stenosis, tortuosity, and associated mural thrombi are seen often. Involvement of the aorta and branches and medium-sized arteries in viscera also have been noted occasionally.[5,9] In the series of 20 patients reported by Kato, et al,[8] results of electrocardiogram were abnormal in 18 patients. Coronary angiograms showed abnormalities in 12 patients, although they noted that,

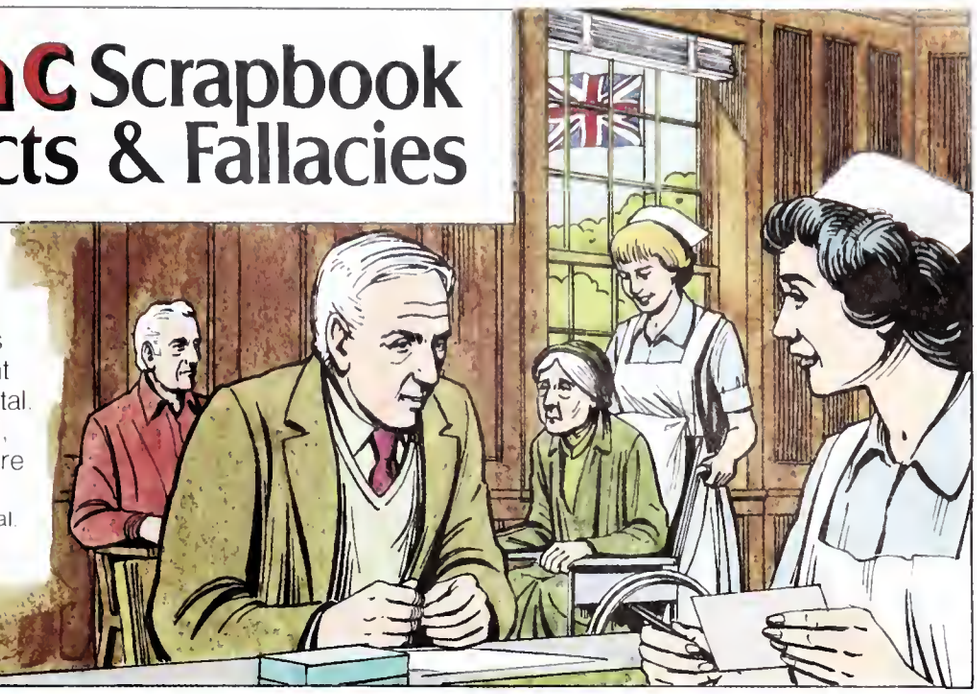
(continued on page 615)

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in serial coronary angiograms, the coronary artery disease tended to regress. The long-term prognosis remains questionable due to the possibility of heart damage in survivors.

Biopsies of cervical lymph nodes in selected patients have revealed swelling of endothelium in postcapillary venules and lymphadenitis with numerous neutrophils and macrophages. Skin biopsies of affected areas have shown dermal edema, capillary dilatation, and mild perivascular infiltration with lymphocytes and monocytes. These changes have been interpreted as being nonspecific.[9] Muscle biopsies have revealed no abnormalities.[7]

Differential Diagnosis

Since no single feature is present in all children with MLNS, the differential diagnosis includes staphylococcal scalded skin syndrome, Rocky Mountain spotted fever, viral syndromes, systemic lupus erythematosus, juvenile rheumatoid arthritis, and allergic reactions. MLNS may be easily confused with scarlet fever. In the latter, the rash appears in skin creases (Pastia's lines), the desquamation is "branny," there is no conjunctival involvement, and penicillin is routinely effective.[6]

Both MLNS and the Stevens-Johnson syndrome are of unknown etiology and show multisystem involvement; however, bullae and exfoliation are unique to Stevens-Johnson syndrome. In the latter, the conjunctivitis is purulent and uveitis may occur. In addition, the fiery-red, stocking-glove distribution of the rash in MLNS is not seen in Stevens-Johnson syndrome.[7]

Etiology

The etiology of MLNS remains undetermined. In most patients, a search for an infectious agent has been made with cultures of blood, urine, cerebrospinal fluid (CSF), and stool for bacterial and viral pathogens, and these have been nonproductive. Viral and bacterial serologies, ASO titer, rheumatoid factor, antinuclear antibody (ANA) titer, and bone marrow aspirations also have been unrewarding. Although selected patients have developed elevations in serum IgA or IgM during the course of the disease,[4] a recent report by Kusakawa and Heiner indicates that most, if not all, children with MLNS develop an elevation in the serum IgE during the acute phase of the illness.[10] Antibiotics have been administered without success to almost all of the patients; neither glucocorticoid nor anticoagulant therapy has been shown to alter the course of the disease.

There was initial excitement when Hamashima, et al reported their discovery of Rickettsia-like bodies by electron microscopy of skin and lymph node biopsy specimens from 12 to 23 patients with MLNS. The bodies were found in the endothelium of arterioles, in the cytoplasm of macrophages, and clustered within the vascular lumen.[11] They also claimed to have isolated a Rickettsia strain from patients' blood by inoculation into yolk sacs after successive inoculation in guinea pigs and mice. Shishido and Adachi were unable to confirm their results, and the lack of response to antibiotics, including chloramphenicol, is inconsistent with a Rickettsial etiology.[2]

Many features of MLNS suggest an infectious etiology and one is tempted to speculate as to whether the microorganism responsible for the syndrome is migrating from Japan to the remainder of the world. MLNS may represent one of the ubiquitous viral syndromes of childhood which only now is being distinguished, and current laboratory techniques have not isolated the virus. There have been incidental findings of American patients with MLNS who had contacted objects from the Far East shortly before the onset of symptoms.[4] The presently unrewarding search for an infectious agent might lead us to rule out this etiology. However, the ultimate success of the workers in the case of the Philadelphia Legionnaires' disease should convince us to continue the search.[12]

An environmental pollutant or yet unidentified toxin has been suggested for the host response seen in MLNS. The elevated IgE found in MLNS might represent a response to an immunogen or hapten and, thereby, contribute to the clinical features of the disease.[10] A specific pattern of drug therapy or allergic reactions to chemical detergents might explain the apparent concentration of the syndrome to a limited geographic area.[3] On the other hand, a toxin which is prevalent in the environment might be responsible for this syndrome. In this case, a genetic predisposition for susceptibility to MLNS and inbreeding of the Japanese population might explain the apparent endemic there. Mortimer has outlined the epidemiologic approach which will be necessary to determine the etiology of MLNS whether it be toxic, allergic, or infectious.[13]

As previously mentioned, in the fatal cases of MLNS, cause of death usually was found to be myocardial infarction secondary to thromboembolism. In each case reported, the pathologic features at autopsy were indistinguishable from a rare entity, infantile periarteritis nodosa (IPN). In this condition, the coronary arteries are affected primarily with a necrotizing arteritis, aneurysm, and thrombosis. Clinical signs and symptoms of IPN include fever, leukocytosis, rhinitis, rash, anemia, abdominal pain, conjuctivitis, edema, myringitis, and cardiomegaly. The disease affects male infants primarily and has a clinical course of a few weeks to months, ending in sudden death.[14] There is considerable overlap between the clinical findings in MLNS and IPN, and Kusakawa and Heiner have suggested that MLNS may represent a disease which may progress to IPN.[10] IPN has been considered a hypersensitivity disease due to its apparent association with several antigens,[15,16] and elevated serum IgE, a finding consistent with MLNS, was discovered in two infants who died from IPN.[17]

More precise separation of these two disease entities, IPN and MLNS, is necessary. IPN currently is regarded as a "collagen disease" with distinct similarities to polyarteritis nodosa which is frequently diagnosed in adults. The carditis in MLNS may be a distinct expression of the syndrome, whereas in IPN the cardiac manifestations

represent only one feature of a disease affecting a variety of organs.

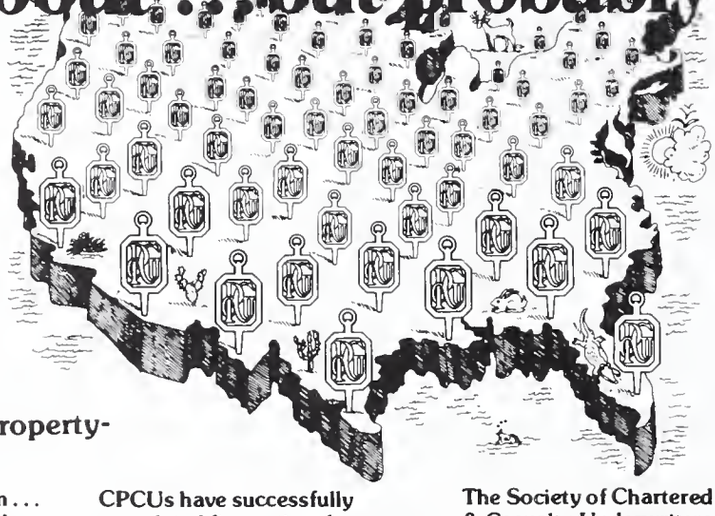
Conclusion

At this point, MLNS represents an elusive-but-significant illness of children. Efforts currently underway in the United States and Japan to determine the cause of MLNS, no doubt, will contribute much to our knowledge of the many poorly understood exanthems of childhood.

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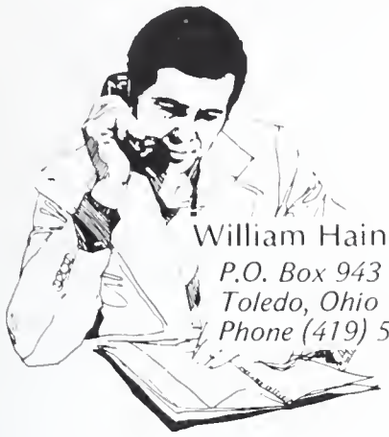
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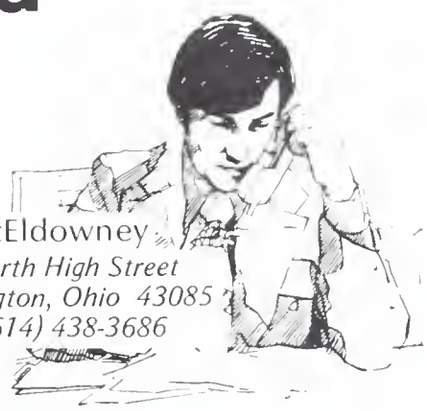


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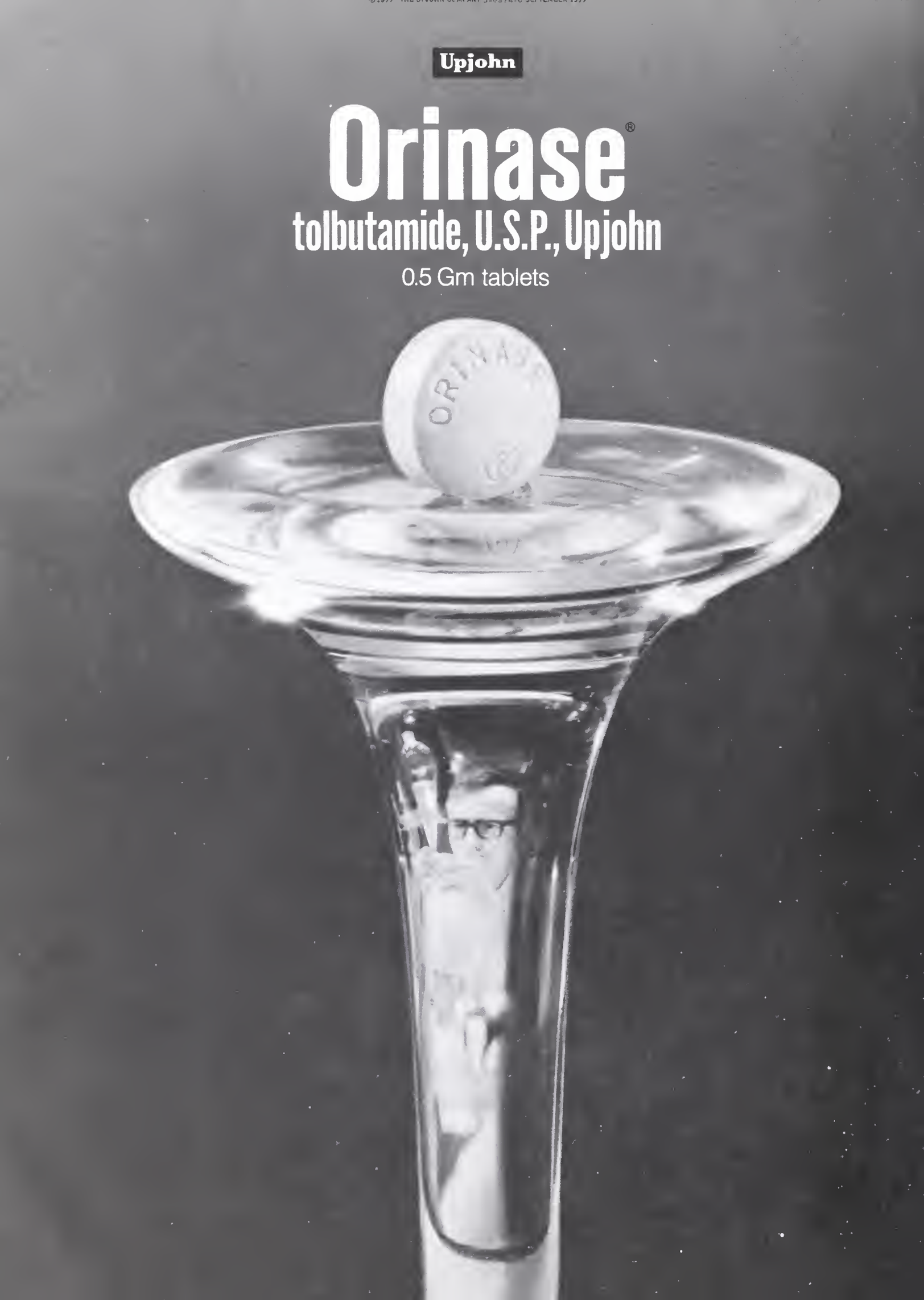
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HLA-B27 Antigen and Rheumatic Diseases

Muhammad A. Khan, M.D.

One of the most exciting advances in rheumatology during the last four years has been the discovery of a strong association between the histocompatibility antigen HLA-B27 and ankylosing spondylitis. This association is so marked that detecton of this antigen serves as a valuable aid in diagnosis and in epidemiologic studies. It has helped in the clarification of the relationship between ankylosing spondylitis and certain other diseases (spondylarthropathies) which have many clinical features in common with ankylosing spondylitis. This article focuses on the genetics of the HLA system and the association of HLA-B27 with ankylosing spondylitis and the related spondylarthropathies.

WITHIN THE LAST TEN YEARS, rheumatology has become one of the most exciting and challenging subspecialties in medicine, and the recent finding of a very strong association of the histocompatibility antigen HLA-B27 with ankylosing spondylitis[1,2] has stirred much interest among rheumatologists, geneticists, immunologists, and histocompatibility experts alike.

The histocompatibility antigens, also called transplantation or tissue antigens, are genetically determined glycoproteins on cell membranes. They also are known as human leukocyte antigens (HLA) because they were originally discovered on leukocytes. Genetic systems resembling the HLA system have been found in all mammalian and avian species that have been investigated so far.

Historical Background

In the 1940s, Medawar noted that skin grafts from a brother to his severely burned sister stimulated a reaction in the sister that resulted in a more rapid rejection of subsequent grafts. He later showed in animal experiments that the accelerated rejection of subsequent grafts was very specific to the particular donor and that immunologic processes were responsible for rejection.

In 1954, Dausset was able to show the presence of histocompatibility system in man by demonstrating the existence of antileukocyte antibodies reacting with foreign leukocyte antigens. Subsequent studies have shown that the antigens are genetically determined glycoprotein molecules expressed on cell membranes, not only of leukocytes but also of platelets and of all nucleated cells. After parenteral contact, eg, transplants, blood transfusions, and pregnancies, these cell surface antigens induce the formation of isoantibodies in an allogeneic host (ie, a genetically different individual of the same species). Besides the ABO blood groups, the HLA antigen matching appears to be very significant to the success or failure of human organ transplantation. Why is a human fetus, which possesses a paternal haplotype of HLA antigens foreign to the mother, not rejected early in pregnancy? A great deal of research has been done but there still is no clear answer to this question, and much more research is necessary to solve this enigma.[3]

Genetics of the HLA System

The frequency of individual HLA antigens in a given population is determined by genetic factors. So far, 51 different HLA antigens have been identified in man. The genetic information which codes for these antigens is present on an area of the sixth chromosome called the major histocompatibility complex (MHC). The responsible genes (gene is an inherited unit located at a locus in a chromosome) have been attributed to four loci designated by the letters A, B, C, and D. Each of the loci is associated with a segregant series of alleles, 20 each at A and B loci, five at locus C, and six at D (Table 1). The HLA antigens are inherited in a simple Mendelian fashion as a series of codominant alleles. The A and B loci are relatively well defined.

Genetic information contained in the chromosomes originates from the parents, half from the father and the other half from the mother. The total genetic information characterizing the HLA antigens of an individual is located on a pair of chromosome 6 (one paternal and one maternal), each having four loci. Thus, in an individual

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(diploid) there are a total of eight (of the yet-known 51 possible) HLA alleles. Depending on whether the individual is homozygous or heterozygous, there are at least four, and up to eight, different HLA antigens detectable in the phenotype, ie, the antigens that are expressed and recognized on the cells of an individual.

Nature did not evolve the HLA system just to frustrate the transplant surgeon. The HLA system must have some other biologic functions. An unusual clustering of the genes coding for many factors involved in immune response now has been found in the MHC region. For example, genes coding for classical (C2, C4, C6, and C8) and alternate (properdin factor B [Bf]) pathways of complement, and the presumptive immune response genes (Ir genes) have been found to be in linkage with HLA genes. This indicates that a very small region (MHC) of the human chromosome 6 may be responsible for the immune recognition as well as the resultant immune response.

HLA-B27-Associated Rheumatic Diseases

Susceptibility to many human diseases now has been found to be associated with certain HLA antigens.[4,5] The most marked associations have been found to be with some rheumatic diseases (Table 2). The closest association yet discovered is the one between ankylosing spondylitis and HLA-B27, first reported in 1973.[1,2] Greater than 90 percent of white patients with ankylosing spondylitis possess B27, as compared to only about 8 percent of normal controls. This association is so marked that detection of this antigen serves as a valuable aid in diagnosis and in epidemiologic studies.[6] Strong association of B27 with ankylosing spondylitis also has been found in other races, eg, American Indians, Arabs, Iranians, Jews, and Japanese.[7] HLA studies have not been carried out in African black patients suffering from ankylosing spondylitis. HLA-B27 is absent in the normal African black population of unmixed ancestry, and ankylosing spondylitis is considered to be extremely rare in them. However, among American blacks, approximately 50 percent of patients with ankylosing spondylitis possess B27, as compared to only 2 percent of normal control.[3-11]

This very strong association between ankylosing spondylitis and HLA-B27 has helped in the clarification of the relationship between ankylosing spondylitis and certain other diseases which have many clinical features in common with ankylosing spondylitis. This group of diseases has been termed "spondylarthropathies" and consists of ankylosing spondylitis, Reiter's disease, spondylitis associated with psoriasis, ulcerative colitis or Crohn's disease, and "reactive arthritis" after Salmonella, Yersinia, or Shigella infections. These diseases often are associated with sacroiliitis, spinal ankylosis, skin or mucosal inflammation, and acute anterior uveitis. All of these arthritides are strongly associated with B27,[4, 12, 13] and have a tendency to familial aggregation. The B27-positive individuals who contract ulcerative colitis, Crohn's disease, psoriasis, or infection with Salmonella, Yersinia, or Shigella organisms are particularly at high risk of developing or having these spondylarthropathies. A number of families have been described in which different members have had different varieties of these spondylarthropathies. HLA-B27-positive individuals also have a high risk of developing acute, anterior uveitis with or without the associated spondylarthropathies.[14]

HLA-B27 antigen probably is not a necessary factor in the pathogenesis of inflammatory arthritis of the sacroiliac joints and the spine. Not all individuals with B27 get ankylosing spondylitis—no more than 20 percent of them will ever have the clinical disease. One can de-

Table 1. New Nomenclature of HLA System

Locus A	Locus B	Locus C	Locus D
HLA-A1	HLA-B5	HLA-Cw1	HLA-Dw1
HLA-A2	HLA-B7	HLA-Cw2	HLA-Dw2
HLA-A3	HLA-B8	HLA-Cw3	HLA-Dw3
HLA-A9	HLA-B12	HLA-Cw4	HLA-Dw4
HLA-A10	HLA-B13	HLA-Cw5	HLA-Dw5
HLA-A11	HLA-B14		HLA-Dw6
HLA-A28	HLA-B18		
HLA-A29	HLA-B27		
HLA-Aw19	HLA-Bw15		
HLA-Aw23	HLA-Bw16		
HLA-Aw24	HLA-Bw17		
HLA-Aw25	HLA-Bw21		
HLA-Aw26	HLA-Bw22		
HLA-Aw30	HLA-Bw35		
HLA-Aw31	HLA-Bw37		
HLA-Aw32	HLA-Bw38		
HLA-Aw33	HLA-Bw39		
HLA-Aw34	HLA-Bw40		
HLA-Aw36	HLA-Bw41		
HLA-Aw43	HLA-Bw42		

Provisionally accepted antigens have prefix "w" for workshop. International Histocompatibility Workshops are held every few years, where HLA numbers are given to well-defined antigens. Less well-defined HLA antigens are given numbers preceded by "w" (HLA-Aw23). A fully defined haplotype is written, for example, as HLA-A2, HLA-B27, HLA-Cw4, HLA-Dw3. When context is clear, it can be written in shorter form as A2, B27, Cw4, Dw3.

Table 2. HLA-B27-Associated Rheumatic Diseases in White Population

Disease	B27(+) %
Primary ankylosing spondylitis	85-95
Reiter's disease	75-90
"Reactive arthritis" after Yersinia, Salmonella, or Shigella infections	67-88
Sacroiliitis or spondylitis associated with psoriasis	52-67
Sacroiliitis or spondylitis associated with ulcerative colitis or Crohn's disease	47-60
Normal controls	6-9

velop ankylosing spondylitis and related spondylarthropathies even in the absence of B27. Except for acute anterior uveitis, there are no clinical or radiologic differences among the B27-positive and negative patients with ankylosing spondylitis.[15] Studies currently are in progress in different research centers to find the specific disease susceptibility gene or genes which lead to ankylosing spondylitis and related spondylarthropathies and which seem to be closely associated with B27 gene.

It should be emphasized that the presence of HLA-B27 is not diagnostic of any disease; it only provides support for the diagnosis of spondylarthropathy. Conversely, its absence does not rule out spondylarthropathy. HLA-B27 typing for ankylosing spondylitis in white patients has an 8 percent "false positive" rate and a little less than 10 percent "false negative" rate. Under appropriate circumstances, eg, when the disease presents in an unusual or atypical manner, or in early stages of ankylosing spondylitis when the patient has back pain and stiffness but has not yet developed typical radiologic changes, detection of B27 can be helpful in making an early diagnosis.

Susceptibility to ankylosing spondylitis and related spondylarthropathies is not as closely associated with HLA-B27 in American blacks as in whites.[8-11] For diagnostic purposes, the absence of B27 is even less important in ruling out ankylosing spondylitis or Reiter's disease in black patients than in white ones since one would expect approximately 50 percent "false negative" results in the former and less than 10 percent in the latter.[9,10]

HLA-B27 determination can be of potential value in assessing statistical risks for ankylosing spondylitis in children of a B27-positive father who has ankylosing spondylitis. If a son has B27, his risk is about 30 percent for developing ankylosing spondylitis or persistent backache. A B27-negative son has less than 3 percent risk for developing the disease and has little chance of passing it on to subsequent generations.[16]

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Pathology

Kathryn P. Clausen, M.D.

PATHOLOGY IS A wide-ranging medical specialty which, strictly defined, is the study of the nature and origins of disease. It is basically laboratory-oriented and is practiced in academic departments, hospitals, clinics, and private laboratories throughout the nation.

Pathology can trace its origins to the medicine of antiquity. The beginning of the era of modern pathology, however, is attributed to Giovanni Morgagni with the publication of his monumental book, *The Seats and Causes of Disease*, in 1761. Perhaps the greatest figure in the history of pathology was Rudolf Virchow (1821-1902), who was the chief pathologist at the Berlin Hospital. He was the founder of the school of cellular pathology, and over his productive, 50-year career, made enormous contributions to the description and understanding of a great many diseases.[1]

The evolution of pathology in America followed the European lead and was initially and largely centered around the autopsy. Autopsy description was often the starting point for the description of a new disease entity and, at a time of less clinical sophistication, often established the actual patient diagnosis. However, newer techniques and ever-increasing clinical sophistication have diminished the diagnostic role of the autopsy although not necessarily its teaching value.[2]

Departments of surgery provided the impetus for the development of cytology and surgical pathology. The leading surgeon of Vienna, Theodor Billroth (1829-1894), is regarded as the founder of the discipline known as surgical pathology.[1]

Exploding knowledge and interest in the biochemical basis of disease, microbiology, and host-parasite relationships, and more recently, immunology and cell biology have all been incorporated into the activities of and services rendered by pathologists to enhance their "study of the nature and origins of disease."

Dr. Clausen, Columbus, Associate Professor of Pathology, The Ohio State University College of Medicine.
Submitted February 1, 1977.

Clinical Practice

Because of its diversity, pathology is divided into a variety of specialties and subspecialties designed to provide the greatest expertise in the delivery of patient care. Depending on the size and type of practice of any given institution, one or a few pathologists may take the responsibility for all pathology services, or specialists may concentrate on a single area. Clinical and patient-related services provided by the pathologist include:

Autopsy.— The most ancient and traditional tool employed by the pathologist in the study of disease is the autopsy. While no longer the means of primary diagnosis, the autopsy is still a valuable means of monitoring the course of disease and effects of therapy. It also is of inestimable value to student and resident teaching. It is a major part of many forensic investigations.

Surgical Pathology.— Surgical pathology applies the techniques of tissue diagnosis to ongoing patient evaluation and is essential to the diagnosis of carcinoma and related diseases. Any institution engaged in surgery of any kind must have the services of a surgical pathologist. While the approach is basically morphologic, it is not limited to gross description and light microscopy. More sophisticated techniques, such as electron microscopy and fluorescent microscopy, have greatly enhanced the diagnostic capability of the surgical pathologist. Rapid diagnosis through the use of frozen sections also provides immediate diagnostic information where such speed is critical.

Cytology.— Most recent of the morphologic techniques of pathology, exfoliative cytology has proved to be of enormous public benefit as a quick and relatively inexpensive means of mass cancer screening, especially for cancer of the uterine cervix. It is now being employed more widely for early diagnosis of lung cancer and, in the future, it may have more diverse applications such as aspiration cytology of breast, prostate, and thyroid.

Blood Banking.— Provision of blood and blood components is an essential feature of modern medical care. It is the pathologist's responsibility to engineer the often

mind-boggling task of maintaining an adequate supply of appropriate types of blood and blood products, often for an entire community or region. He also must supervise and take professional responsibility for accuracy of typing and crossmatching. He must respond to the needs of the individual patients and their physicians, at the same time allocating sometimes-limited resources in the most effective way for the whole community. He should be a consultant on the most appropriate use of components and blood products. Newer innovations in blood banking include plasmapheresis and leukopheresis, use of histocompatibility antigens as well as red cell antigens for more refined crossmatching (and paternity testing), and the uses of frozen blood.

Clinical Immunology.— Some of the most exciting new areas in laboratory medicine are in clinical immunology. This formerly dealt primarily with serologic testing for antibodies to syphilis and other infectious diseases. But advances in technology have added the capability for studies of abnormal antibodies (antinuclear factors, rheumatoid factors, and others) and both the identification and quantitation of immunoglobins by the use of immunoelectrophoresis. Fluorescent techniques now permit T- and B-cell quantitation and typing of lymphomas. Many new applications for these techniques are being identified constantly.

Clinical Hematology.— One of the busiest laboratories in any hospital is the hematology laboratory, which usually includes urine and coagulation testing in its services. The pathologist is responsible for the generation of accurate, reliable data— both quantitative and morphologic. He should be consulted on unusual cases and on coagulation problems, not only performing the tests but suggesting the most appropriate tests and interpreting their results.

Automation in the hematology laboratory is advancing rapidly with expectations for automated morphologic identification of cells, as well as cell count, in the near future.

Clinical Chemistry.— Chemistry encompasses the study of chemical aspects of life process with the application of chemical laboratory methods to diagnosis and treatment. Clinical chemistry emerged as an identifiable pathology specialty following World War I, when workers such as Van Slyke and Smogyi helped to advance technology to a point of practical applicability to patient care. Chemistry has taken the lead in automation and mechanization in the hospital laboratory. For example, this has led to the use of low-cost admission and screening batteries and has reduced costs of many tests, at the same time increasing reliability and reproducibility. Procedures once considered exceptional, such as blood gases, are now routine in most laboratories. Most recently, chemical pathologists have taken the lead in the development of computerized patient data records resulting in rapid retrieval and laboratory/computer interface.

Microbiology.— Clinical microbiology actually originated with Pasteur and Koch. Edwin Klebs (1834-1913) probably did the most in the early days to align bacteriology with pathology.[1] The modern practice of clinical microbiology goes much further, however, than the simple identification of organisms. Automated techniques now are replacing many of the old, manual, plating techniques for isolation and characterization of organisms. Microbiological assays are being made to determine drug levels in the blood. There are new methods for anaerobic isolation and culture and fluorescent dyes for acid-fast recognition. In addition to these services, the pathologist-microbiologist is an active participant in infection control and should be a consultant at the bedside of patients with special problems regarding infection.

In the future, the virus laboratory may become a part of the standard microbiology division in the hospital.

Teaching and Research

Currently, there are 143 academic departments of pathology in the United States and Canada. All of these departments conduct active research programs in many areas ranging from molecular biology through all types of clinical investigation. Most of these departments offer master's and doctorate degrees, in addition to playing a major role in undergraduate medical education.[3]

To the medical student, pathology is the "bridge" between the basic sciences and clinical medicine. As such, it occupies an important place in every undergraduate medical curriculum.

In recent years, emphasis on the morphologic aspects of pathology has diminished while, at the same time, there has been increasing emphasis on the clinical laboratory and its application to medical care. Currently, there is a great deal of change in and re-evaluation of the role of pathology in the medical curriculum as well as the relative merits of the "classical" morphologic approach versus the "modern" approach of laboratory medicine. Academic departments of pathology also differ in their teaching philosophy, depending on their own administrative structure. Most still combine the academic and administrative elements of all areas currently covered under the umbrella of "pathology" in one academic department. Some colleges, however, have established separate departments of anatomic pathology and laboratory medicine. Inevitably, this has an effect on the character of pathology in the curriculum and the manner in which it is presented to the students.[2] Regardless of the approach, however, pathology is an important course for all medical students and remains a major time commitment in the second year or its equivalent. Academic pathologists spend a large portion of their time in teaching students, not only medical students but allied health, graduate, and other professional students as well. Nevertheless, whether affiliated with academic institutions or not, the pathologist is expected to teach. He often organizes and presents a variety of hospital conferences and classes, and is a useful participant in many specialty conferences.

Indeed, the opportunity to teach may be an important reason many of them choose pathology as a career.

Training and Career Opportunities

Currently, 210 hospitals or other institutions in North America are accredited by the Council on Medical Education of the American Medical Association and the American Board of Pathology to train residents in pathology and its subspecialties.[3]

Basic certification is offered in anatomic pathology, clinical pathology, or both. Either one singly requires three years of specific training and one year of additional experience. Combined boards require four years' training in all of the specialties.

In addition, subspecialty certification can be obtained with extra training and qualifying examinations in chemical pathology, hematology, medical microbiology, blood banking, radioisotope pathology, neuropathology, and forensic pathology. Specific information on programs and requirements can be obtained by writing directly to the American Board of Pathology, Suite 1820, Exchange National Bank Building, Tampa, Fla. 33602.

Conclusion

The practice of medicine is changing in this country, and the practice of pathology is changing with it. This change has been influenced by the increase in technology, rising public expectation, and changing patterns of government regulation and fee payments. It has been predicted that the general pathologist may disappear in the future and be replaced by a variety of specialists and subspecialists in the areas described in this article. It also is likely that training programs will be curtailed and limited to university centers.[4]

Whatever happens, however, there can be no doubt that the practice of pathology currently is one of the most interesting, professionally satisfying, and rapidly expanding areas of medicine. There are some who sincerely believe that the medicine of the future is in the laboratory. Perhaps they are right.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Progress Report on the First Session of the 112th Ohio General Assembly

D. Brent Mulgrew, J.D., Director, and
Richard A. Ayish, Assistant Dirccor,
OSMA Department of State Legislation

The 112th Ohio General Assembly has concluded most of the work of the First Session, and the Legislature has recessed for the summer. The General Assembly will reconvene in early September, meeting sporadically until January 1978 when the Second Session begins.

During the First Session, Ohio's legislators introduced more than 1,200 bills and conducted approximately 2,600 hearings. So far, 167 bills have become law. The OSMA Department of State Legislation has been very busy due to the large number of bills being considered that affected the medical profession. The Department monitored more than 100 pieces of legislation and actively lobbied 35 bills.

In spite of the number of bills involved, OSMA's legislative program has been successful. The Department of State Legislation promoted OSMA legislative proposals and dealt with the legislative initiatives of other groups. Many bills were proposed by non-medical practitioners who were attempting to expand their scope of practice into the medical arena

As OSMA's lobbyist, the Department of State Legislation represents the policies of the OSMA to the members of the Legislature. Physician contacts with local legislators cement the work done by the Columbus staff.

OSMA-member contacts spell the difference between success and failure in these legislative efforts. Physician assistance at the local level has been good on a few issues and nonexistent on many others. To be effective, both local physicians and the OSMA Department of State Legislation must be ready to provide assistance and explanation on technical medical matters to legislators.

The OSMA was involved in the following major issues considered during the First Session of the 112th Ohio General Assembly. Also included is a list of bills the Department of State Legislation has been monitoring in 1977. The listing indicates the sponsor, subject, and status as of the recess of each bill. Although the OSMA does not have a position on each of the listed bills, all of them may have an impact on the way health care is delivered to the residents of Ohio.

Informed Consent (HB 213)

The OSMA was successful in repealing the cumbersome, alternative, statutory informed consent form included in last session's Medical Malpractice Act (HB 682). In addition, HB 213 (Murdock, R-Cincinnati) eliminates any potential hospital liability for a physician's failure to obtain an informed consent except when the physician is an employee of the hospital. Rep. Murdock worked closely with the OSMA to repeal the statutory form and the "laundry list" of possible complications, making informed consent the physician's responsibility on a case-by-case basis.

Hospital Patient's Bill of Rights (SB 202)

The Department of State Legislation substantially amended SB 202 (Valiquette, D-Toledo), the so-called "Hospital Patient's Bill of Rights." The Senate subcommittee reviewing the legislation recognized the potential problems SB 202 would create and amended the bill positively. Although OSMA opposes the legislation mandating standards of practice, there is a great deal of political pressure behind SB 202. The amended version deletes most of the major objections of the OSMA to the bill, including deletion of the direct-access-to-court for rights violations provision.

Extension of the Joint Underwriting Association (SB 299)

The OSMA supported SB 299 (O'Shaughnessy, D-Columbus), which was enacted. The bill permits the Joint Underwriting Association (JUA) to continue to offer medical malpractice insurance to physicians for another two years. Without this legislation, the JUA would have stopped selling medical malpractice insurance as of December 31, 1977.

Legalization of Laetrile (HB 650)

In May 1977, the OSMA House of Delegates adopted a position of opposition to HB 650 (Sweeney, D-Cleveland), a bill to legalize the sale and administration of

(continucd on page 629)

The charts on pages 627-629 give a synopsis of bills monitored by the OSMA Department of State Legislation during the First Session of the 112th Ohio General Assembly. Bills introduced in the House are listed first, followed by those introduced in the Senate.

Bill	Sponsor	Subject	Current Status
		BILLS INTRODUCED IN HOUSE	
HB 8	Branstool	Exempts insulin from sales tax	Ways and Means
HB 76	Healy	Repeals fluoride requirements in public water supplies	Governmental Affairs
HB 115	Tranter	Repeals motorcycle helmet law	Passed House, approved by Senate Highways & Transportation 7-27-77
HB 137	Deering	Registration of sanitarians	Law, effective 8-15-77
HB 151	Orlett	Repeals Ohio's anti-substitution drug law	Judiciary
HB 162	Jones	Requires motorcycle education courses	Education
HB 164	Leonard	Extends deadline for hearings of hospitalized mentally ill persons required by HB 244	Law, effective 2-21-77
HB 167	Maddux	Requires legislative purpose statements for all bills	Finance
HB 169	Maddux	Establishes minimum educational requirements for emergency medical personnel	Governmental Affairs
HB 177	Deering	Revises payment of state subsidies to health districts	Finance and Appropriations
HB 185	Saxbe	Repeals motorcycle helmet requirement	Transportation & Urban Affairs
HB 191	Shoemaker	Governor's biennial appropriations bill	Law, effective 6-30-77
HB 204	Lehman	Requires signs warning persons with pacemakers that microwave ovens are present in food establishments	Health and Retirement
HB 209	Rankin	Transfers regulation of physical therapists from State Medical Board to Board of Physical Therapy	Passed House and now in Senate
HB 213	Murdock	Amends informed consent statute	Passed House and Senate
HB 252	Begala	Establishes a department of geriatric medicine at state supported medical schools	Passed House and Senate Awaits Governor's signature
HB 267	Lehman	Provides for jury exemption of physicians at their request; repeals automatic exemption	Passed House and Senate Awaits Governor's signature
HB 282	Bell	Appropriation for sickle cell anemia research	Finance and Appropriations
HB 298	Nader	Determination of death	Judiciary
HB 319	Cook	Clarifies statute of limitation in product liability & establishes 12-year statute of limitation	Passed House, now in Senate Judiciary
HB 331	Lancione	Requires General Assembly to review certain agencies for their continued existence	Passed House, now in Senate Judiciary
HB 346	Tranter	Revises product liability statutes & establishes a statute of limitation based on useful life of product	Insurance, Utilities & Financial Institutions
HB 353	Hale	Establishes a council to set drug prices & create a list of drugs that are equivalent for substitution	Judiciary
HB 354	Hale	Provides for a reduction in amount of fluoride permitted in public water supplies by 1980	Governmental Affairs
HB 355	Hale	Requires study of venereal disease in grades 7-12	Health and Retirement
HB 378	O'Neill	Expands licensing program for residential care facilities for the mentally retarded to include developmentally disabled	Health and Retirement
HB 383	Begala	Makes Dept. of Public Welfare responsible for social services program under Title XX; appointment of County Welfare Advisory Board	Passed House and Senate
HB 390	Galbraith	Designates the office of coroner as an appointive office	Governmental Affairs
HB 408	Rankin	Makes an $8 million supplemental appropriation to Welfare Department for emergency assistance for current fiscal year	Finance and Appropriations
HB 410	Fries	Expands Attorney General's anti-trust investigatory powers	Passed House and now in Senate Judiciary
HB 413	Sweeney	Requires the Public Health Council to adopt rules probihiting discrimination by hospitals in staff membership and professional privileges	Passed House, now in Senate Education and Health
HB 443	McLin	Requires establishment of programs for residency training positions in primary care medical fields	Approved by Health & Retirement, rereferred to Finance and Appropriations
HB 490	Christman	Creates a Department of Health, Education and Planning	Rereferred to Finance and Appropriations
HB 516	Stinziano	Permits an individual to direct that no medical maintenance be administered if condition is terminal	Health and Retirement, rereferred to Judiciary
HB 546	Carney	Changes the title "massage" to "manual therapy"	Governmental Affairs
HB 557	Wargo	Allows businesses to pay administrative costs of administering political check-offs for employees	Passed House and Senate

Bill	Sponsor	Subject	Current Status
HB 592	Brown S	Permits use of saccharin	Approved by Commerce and Labor 6-8-77
HB 598	Skeen	Permits civil actions against employers who discriminate on the basis of age	Passed House, now in Senate Commerce and Labor
HB 600	Hartley	Establishes nursing home "patients' bill of rights"	Judiciary
HB 604	Hartley	Makes age discrimination illegal	Economic Affairs and Federal Relations
HB 650	Sweeney	Regulates use of laetrile	Passed House, now in Senate Education and Health
HB 674	McLin	Establishes College of Professional Psychology at Wright State	Education
HB 687	Batchelder	Mandates VD testing of pregnant women prior to delivery	Health and Retirement
HB 698	Locker	Licenses general and special counselors	Approved by Economic Affairs and Federal Relations
HB 704	Hale	Provides for licensing of adult foster care facilities	Passed House, now in Senate Education and Health
HB 709	Orlett	Permits the use of heroin in experimental drug maintenance treatment programs	Passed House, now in Senate Judiciary
HB 710	Hale	Requires courses in family living be offered to grades 6-9	Education
HB 725	Leonard	Revises HB 244 (111th G.A.), mentally ill patients' rights	Passed House, now in Senate Judiciary
HB 747	Kurfess	Revises lobbying accounting and reporting law	Introduced 6-7-77
HB 755	Lehman	Includes reciprocal medical malpractice insurer in JUA	Insurance, Utilities and Financial Institutions
HB 762	Camera	Extends unemployment benefits to new classes of employees	Passed House, now in Senate Commerce and Labor
HB 773	Hale	Establishes a state board to provide services to pregnant teenagers	Finance and Appropriations
HB 840	Rocco	Extends immunity from civil liability to certain medics	Governmental Affairs
HJR 4	Jones	Memorializes Congress to fully fund Medicaid Program	Passed House, now in Senate Finance
HJR 35	Jones C	Establishes a legislative study commission to investigate rising hospital and medical costs	Adopted by House 7-28-77
HCR 14	Leonard	Disapproves the proposed Ohio rules of evidence	Adopted
		BILLS INTRODUCED IN SENATE	
SB 14	Freeman	Requires periodic review by legislature of continued existence of all state agencies	Judiciary
SB 23	Carney	Provides for registration of sanitarians and sanitarians in training	Conservation and Environment Postponed indefinitely
SB 31	Carney	Includes alcoholism coverage in sickness and accident insurance policies	Elections, Financial Institutions and Insurance Subcommittee
SB 36	Freeman	Requires the Depart. of Welfare to contract with 3rd party for paying medical assistance claims	Finance
SB 40	Valiquette	Requires additional officials to file financial disclosure statements	Passed Senate and House, referred to Conference Committee
SB 45	Freeman	Repeals anti-substitution drug laws	Law effective 1-1-78
SB 71	McCormack	Expands licensing program for residential care facilities to include developmentally disabled persons	Passed Senate and House
SB 90	Stano	Provides coverage for mental and emotional disorders and alcoholism in insurance plans	Approved by Elections, Financial Institutions and Insurance Committee
SB 91	Butts	Requires employers to grant paid time off for workman's compensation hearings	Passed Senate, now in House Commerce and Labor
SB 130	Jackson	Authorizes the administration of anesthetics by qualified persons under direction or in presence of licensed physician	Passed Senate 7-23-77
SB 134	Roberto	Permits Wright State U. & Northeastern Ohio U. Cols. of Medicine to use funds to improve property owned by hosp. corporations	Law, effective 5-6-77
SB 138	Mussey	Authorizes persons undergoing training for EMT-A and paramedics to ride in ambulances and emergency vehicles	Education and Health
SB 143	Aronoff	Clarifies and strengthens the 1975 privacy act	Judiciary
SB 157	Calabrese	Prohibits restraints on advertising cost of eyeglasses & requires copies of prescription be given to patient	Approved by Education & Health 7-27-77

Bill	Sponsor	Subject	Current Status
SB 159	Meshel	Empowers the attorney general to recover Medicaid overpayments	Finance
SB 163	Jackson	Requires diagnostic pharmaceutical agent's license before optometrist may use diagnostic drugs & changes license of optometrists	Approved by Education and Health, now in Rules
SB 172	Bowen	Permits G.A. to invalidate state agency rules & establish joint legislative committee to review state agency rules	Ways and Means
SB 177	Maloney	Restricts the introduction of bills & requires standing committees to exercise legislative oversight during 112th G.A.	Ways and Means
SB 178	Maloney	Requires each General Assembly to set dates for the completion of its legislative business	Ways and Means
SB 202	Valiquette	Hospital patients' "bill of rights"	Approved by Education and Health
SB 203	Valiquette	Makes privileged information of that acquired while providing counseling to sexual assault victims	Passed Senate, now in House Judiciary
SB 216	McCormack	Provides for control of lobbying	Judiciary
SB 221	Meshel	Companion bill to HB 191 (budget act), contains appropriation language	Passed Senate and House
SB 224	Aronoff	Clarifies provisions of the privacy act	Passed Senate and House
SB 233	Calabrese	Nursing home patients' "bill of rights"	Education and Health
SB 237	Meshel	Authorizes conditions for Welfare Dept. to make demonstration project grants aimed to encourage facilities for care of persons eligible for medical aid	Passed Senate and House
SB 240	Bowen	Permits advertising for professional services	Passed Commerce and Labor
SB 253	Maloney	Extends insurance equity laws	Elections, Financial Institutions, & Insurance
SB 258	Roberto	Substitutes a form of comparative negligence for the common law doctrine of contributory negligence in determining recovery in negligence actions	Passed Senate, now in House Insurance, Utilities, and Financial Institutions
SB 272	Meshel	Establishes certain classes for determining rates for individual subscription contracts of hospital service associations	Elections, Financial Institutions and Insurance
SB 282	Celebrezze	Requires schools to maintain vaccination and immunization records	Passed Senate, now in House Education
SB 283	Valiquette	Congressional redistricting bill	Passed Senate, now in House Governmental Affairs
SB 285	Bowen	Licenses general and special counselors	Passed Senate, now in House Economic and Federal Relations
SB 294	Mahoney	Clarifies method for making anatomical gifts by statements on driver licenses or endorsements	Approved by Education & Health 7-27-77
SB 299	O'Shaughnessy	Extends existence of the JUA for two years	Passed Senate and House
SB 307	Van Meter	Requires gonorrhea test just prior to delivery	Education and Health
SB 314	Butts	Protects third party payor from civil liability suits	Judiciary
SB 315	McCormack	Transfers jurisdiction over the treatment and control of alcoholism from Depart. of Health to Depart. of Mental Health & Mental Retardation	Education and Health
SB 322	Carney	Liberalizes Ohio unemployment compensation laws	Commerce and Labor
SB 328	Roberto	Establishes Ohio Optical Dispensers Bd. & requires licensing of optical aid dispensers	Education and Health
SB 331	Mahoney	Provides for licensing home health agencies by the Health Department	Education and Health Subcommittee
SB 347	Nabakowski	Extends immunity from civil liability to emergency medical technicians or paramedics in training	Education and Health
SJR 17	Bowen	Requests the Ohio Supreme Court to allow attorneys to advertise	Rules Committee

Laetrile (amygdalin). The resolution stated that if the Ohio Legislature passed this legislation, Laetrile should be made an over-the-counter product available without prescription. The Department of State Legislation followed this mandate in amending HB 650 to permit total over-the-counter sale of Laetrile. The bill is now in the Senate Education and Health Committee, where it has not yet received its first hearing.

Chiropractic Rules' Expansion Withdrawn

The Department of State Legislation testified at the Ohio State Board of Chiropractic Examiners' hearing against a proposed rule expanding the scope of the practice of chiropractic. The proposed rule would have granted

(continued on page 630)

chiropractors the right to draw blood for diagnostic samples, "apply casts and other orthopedic devices," administer "therapeutic substances," and use psychological therapeutic procedures designed to assist in the restoration and maintenance of neurological integrity and homeostatic balance. The proposed rule was withdrawn after the opposition testimony by the OSMA.

Use of "Diagnostic Pharmaceuticals" by Optometrists (SB 163)

The Department of State Legislation, working closely with the Ohio Ophthalmological Society, has succeeded in holding SB 163 (Jackson, D-Cleveland) in the Senate Rules Committee where the bill could stay indefinitely and die. SB 163 permits optometrists to administer "diagnostic drugs." Physician contact with members of the Senate Rules Committee (See *The Journal,* Vol. 73, No. 8, August 1977, page 515.) and local senators has been of great assistance and continues to be of great importance if the bill is to be kept from the full Senate for a vote. The bill was amended successfully to remove the expansive definition of the practice of optometry, but it still contains the major issue of nonmedical practitioners seeking to administr dangerous drugs in a patient's eyes. This bill needs personal physician contact with Senate Rules Committee members and local senators during the recess.

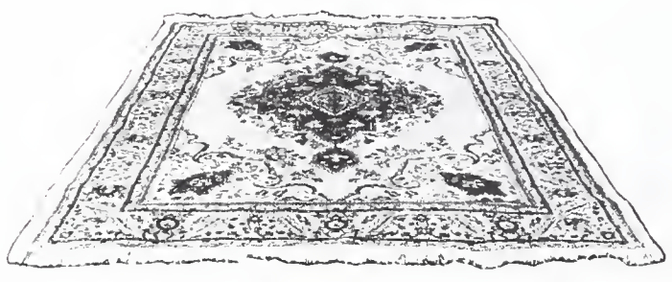
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Repeal of Ohio's Anti-substitution Law (SB 45)

In attempting to stop SB 45 (Freeman, D-Canton) to repeal Ohio's anti-substitution law, the OSMA waged a difficult battle against the Ohio AFL-CIO, Ohio Council of Retail Merchants, and Ohio Pharmaceutical Association. Although the bill passed, the OSMA added three amendments: (1) to permit a physician to prohibit a substitution by writing "Dispense As Written"; (2) to clarify the liability exemption for physicians; and (3) to require the pharmacist to indicate on the container label "Generic Substitution Made." In addition, a consumer amendment supported by the OSMA was added over the objection of the pharmacists. This amendment requires the pharmacist to pass on to the patient the cost savings attributable to the substitution of a generic product. The amendment ensures that the consumer will be the one who profits from alleged savings of substitution. The bill becomes effective January 1, 1978.

Revision of Commitment Procedures for the Mentally Ill (HB 725)

The House approved OSMA-supported HB 725 (Leonard, D-Dayton), revising commitment procedures and mental patients' rights contained in last session's HB 244. The Department of State Legislation worked with Rep. Leonard on solutions to the problems created by HB 244, and the Department has found HB 725 to be a practical solution which can be supported. The bill simplifies commitment procedures, permitting physician testimony by written deposition, providing it contains adequate evidence and makes the probable-cause hearing more informal. The bill is pending in the Senate.

Physician Jury Duty Exemption (HB 267)

HB 267 (Lehman, D-Cleveland) amended Ohio's jury duty exemption statute to remove existing jury duty exemptions for most professions that enjoyed exemptions in the past. The OSMA retained the physician exemption to jury duty. A physician need only apply in writing for the exemption.

Regulation of Physical Therapists (HB 209)

HB 209 (Rankin, D-Cincinnati) originally contained changes in the existing definition of the practice of physical therapy that were vigorously opposed by the OSMA. The Department of State Legislation, working closely with local physicians, amended the bill to remove most of the objectionable sections. Although the OSMA opposed the removal of physical therapists from the jurisdiction of the State Medical Board to a combined Occupational Therapy-Physical Therapy Board, there was strong sentiment in the General Assembly that this group should have their own board. The Department of State Legislation was successful in inserting language into HB 209 that requires that a physician be a full voting member of the physical therapy section of the board.

When Griseofulvin is indicated...



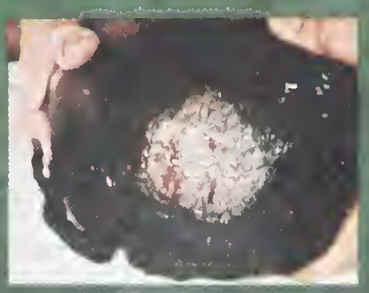
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



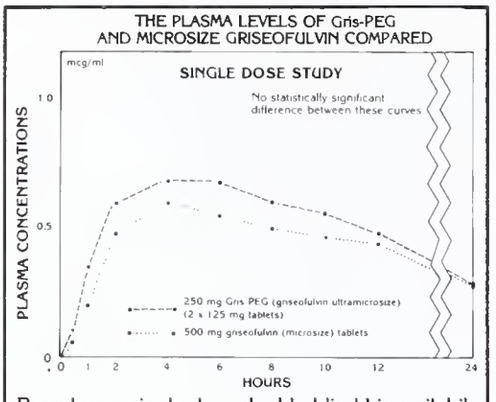
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Please see other side for full prescribing information.

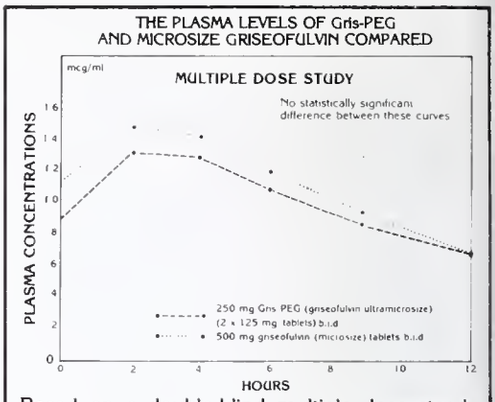
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin

ACTION

Microbiology Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi

Human Pharmacology: The peak plasma level found in fasting adults given 0 25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1 6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0 5 g occurs at about four hours and ranges between 0.44 to 1 2 mcg/ml

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone

Griseofulvin is *NOT* effective in the following

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin

WARNINGS

Prophylactic Usage. Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0 5 to2 5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males Smaller particle sizes result in an enhanced effect Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy. The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies. It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities

Proteinuria and leukopenia have been reported rarely Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YE

THE OHIO STATE Medical Association News

Ohio Dept. of Health Initiates Screening Program for Primary Neonatal Hypothyroidism

The Division of Maternal and Child Health of the Ohio Department of Health is initiating a pilot program for screening newborns for primary neonatal hypothyroidism. The Handicapped Child Committee of the Ohio Chapter of American Academy of Pediatrics has selected Cuyahoga, Franklin, Lucas, and Summit Counties as the pilot areas for the program. These counties were selected because of the availability of pediatric endocrinologists to provide consultation and follow-up of any infants detected in the screening program. The target date for implementing the pilot screening program is the summer of 1977.

The estimated frequency of congenital hypothyroidism is about 1 in 6,000 births, significantly more common than phenylketonuria. Neonatal hypothyroidism is an established cause of mental retardation which may be prevented by thyroid replacement therapy before three months of age. Lifelong therapy with thyroid hormone is the usual prescription for hypothyroid infants.

Current studies indicate that with replacement thyroid therapy initiated prior to three months of age, there is a 70- to 80-percent chance the baby will have normal intelligence. However, if treatment is delayed beyond six months, the baby will have a 90-percent chance of being mentally retarded.

Oregon, Massachusetts, Rhode Island, Maine, Connecticut, and Pennsylvania[1] are currently screening newborns for hypothyroidism. Serum thyroxine levels (T_4) are determined using filter paper spots (utilizing blood samples from PKU filter paper). If the T_4 level is questionable, the test is repeated and followed by thyroid stimulating hormone (TSH) test. The time lapse for these tests is minimal, and an infant identified as potentially having primary neonatal hypothyroidism can be further evaluated by a pediatric endocrinologist and thyroid replacement can be initiated.

References

1. Fisher DA: Recommendations for screening programs for congenital hypothyroidism. *Amer J Med* **61**:932-934, 1976.

Washington Physician Chairman AMA Board of Trustees

The new chairman of the AMA Board of Trustees is Washington physician Robert B. Hunter, M.D. A member of a three-man partnership in general practice and surgery, Dr. Hunter was first elected to the AMA Board of Trustees in 1971. Prior to that election, he had served as a member of the House of Delegates and the Council on Constitution and Bylaws. Dr. Hunter, who graduated from the University of Pennsylvania Medical School in 1943, is one of 11 physicians appointed to the National Professional Standards Review Organization Council, a member of the clinical faculty of the University of Washington School of Medicine, and a charter member of the American Board of Family Practice.

Toledo Academy of Medicine Makes Donation to Public Television

The Academy of Medicine of Toledo and Lucas County has donated $1,000 to Toledo television station WGTE to keep the children's program, "Sesame Street," on the air. The station has announced that after November 1977, it stands to lose $11,000 of the $32,700 needed to broadcast the program locally because of a ruling by officials of the U.S. Department of Housing and Urban Development that the city of Toledo can no longer divert community development block-grant money to help pay for the program.

In a letter to the public television station, officials of the Academy said they hope the donation will encourage other organizations to follow with contributions of their own to help offset a threatened loss of a third of the program's annual budget.

"This action is being taken because of the excellent reputation of 'Sesame Street,' and is reflective of the tremendous interest that the Academy of Medicine has in overcoming the excessive flaunting of violence on TV," they stated.

Lamont McLaughlin, WGTE's director of development and administration, said that the Academy's donation was unsolicited and came in response to a June article in the *Toledo Blade*.

Public Opinion Divided on Hospital Revenue Ceiling

Public opinion is evenly divided between the Carter Administration's proposed 9 percent cap on hospital revenues and the alternative proposal of Senator Herman Talmadge (D-Ga.). This is information gathered through the national public opinion survey conducted during July 1977 by Louis Harris & Associates for the Federation of American Hospitals (FAH).

The survey also determined that nearly two-thirds of the people feel that price controls on hospital revenues, without controls on labor and supplies, are unfair. Ac-

(News continued on page 643)

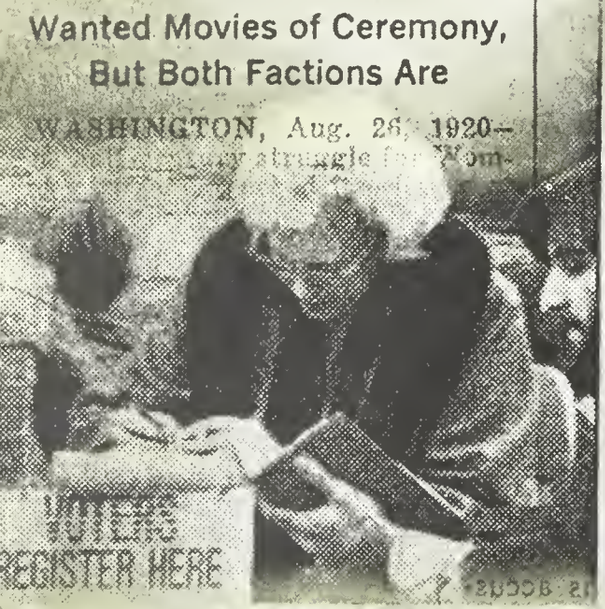
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Joble

Roosevelt Approves Message Intended to Benefit 30,000,(Persons When States Adopt Cooperating Laws–He Cal the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 19
The Social Security Bill, provi
a broad program of unemployn
insurance and old age pensi
and counted upon to benefit s
20,000,000 persons, became law
day when it was signed by P
dent Roosevelt in the presenc
those chiefly responsible for
ting it through Congress.

Mr. Roosevelt called the mea
"the cornerstone in a struc
which is being built but is by
means complete

COMP

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

JUL SIGNE the Draft Ends Nov

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

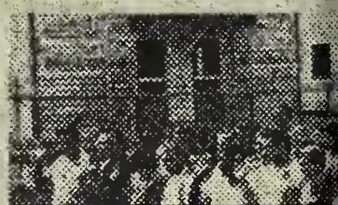
Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

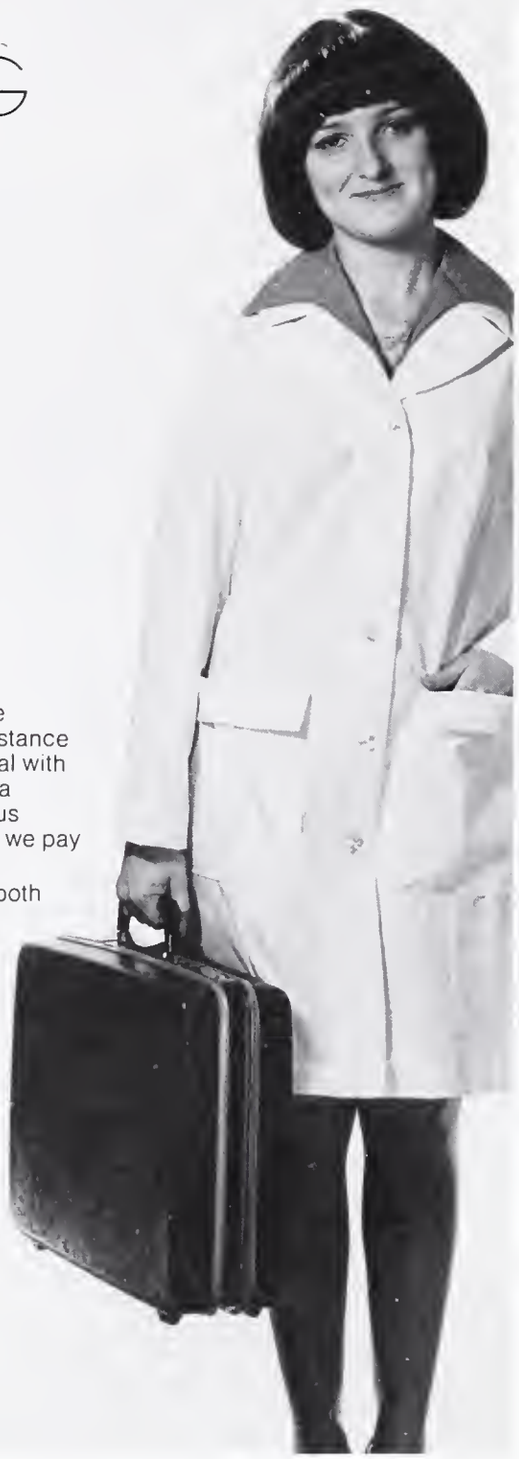
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

Your hospital's complete EEG laboratory!



Daneman Laboratories' space-age electronics technology and two long-distance telephone calls will provide your hospital with same-day EEG and ECHO readings by a qualified neurologist. Even instantaneous reports can be provided if needed. And we pay for the phone calls!

This service has wide benefits for both hospital and patient:

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The Physician's Assistant

Prepared by the Members and Staff of the Ohio State Medical Board

During 1976, the Ohio General Assembly enacted House Bill 663, which established registration of physician's assistants with the State Medical Board. This requirement for registration has resulted in a number of recurring questions.

What Is a Physician's Assistant?

Section 4730.01, Ohio Revised Code, defines a physician's assistant as ". . . a skilled person qualified by academic and clinical training to provide services to patients under the supervision and direction of a licensed physician or group of physicians who are responsible for his performance."

A physician's assistant may function in any setting in which the employing physician or physicians routinely practice. The employing physician or physicians assume legal liability for the services provided by the assistant.

It is important to note that the new law also reserves the use of the terms *physician's assistant, P.A.,* or any other words or letters indicating or implying that a person is a physician's assistant to those registered with the State Medical Board.

Who Is Eligible to Register With the Board?

An applicant for registration must be certified by the National Commission on Certification of Physician's Assistants as having passed its examination. This examination is currently administered on a nationwide basis once a year, usually in October or November.

Persons interested in taking this examination should contact the National Commission (3384 Peachtree Road, N.E., Suite 560, Atlanta, Georgia 30326) rather than the Medical Board since the Board neither determines eligibility for nor administers this examination. Eligibility to take this examination is normally based upon completion of two years of formal training in a primary care physician's assistant program, although the Commission may declare informally trained persons eligible.

The Medical Board may issue a temporary certificate of registration on behalf of individuals who have been declared eligible to take the National Commission examination. However, the temporary certificate is valid only until the results of the next examination are available to the Board.

How Does One Apply for Registration?

Either the physician's assistant or an employing physician should write the State Medical Board (180 East Broad Street, Suite 1006, Columbus, Ohio 43215) and request an application for registration or temporary registration.

Information requested in the application is based upon statutory requirements. The applicant must submit satisfactory proof that he/she is at least 18 years of age and is of good moral character. In addition, the employing physician or physicians must attach a statement indicating the manner and extent to which the physician's assistant will be used and supervised. The Medical Board is also authorized to request any other information that it may require.

Upon receipt at the Medical Board office, the application for registration is reviewed for accuracy and completeness and then is submitted to the Board for consideration.

If the Medical Board has any questions concerning a particular application, it is not unusual for the Board to request the applicant and an employing physician to appear at the next Board meeting to discuss the proposed functions of the physician's assistant. In its deliberations, the Board carefully reviews the credentials of the employing physician or physicians as well as those of the physician's assistant.

If the Medical Board decides to approve a registration or temporary registration, a certificate of registration will be issued to the employing physician. This registration authorizes the physician's assistant to perform only those functions contained in his application to the Board.

Upon termination of an assistant's employment with the physician or physicians to whom his/her certificate of registration is issued, the registration is immediately suspended. The physician or physicians must inform the Medical Board of this termination within two weekdays after cessation of employment. If the employment is terminated by or at the request of the employing physician or physicians, the reason for termination must be given to the Board.

Guidelines Governing Physician's Assistants

At its June 1977 meeting, the Ohio State Medical Board adopted the following guidelines pertaining to physician's assistants:

Functions

(A) A patient new to the physician's practice must be seen and personally evaluated by the employing physician during the patient's initial visit. An established patient with a new condition must be seen and personally evaluated by the employing physician during the initial visit for that condition.

(B) The physician's assistant may perform any of the following functions only under the supervision of the employing physician or physicians and only while the employing physician or physi-

(continued on page 638)

Physician's Assistant *(continued)*

cians are available for immediate consultation, provided that the particular functions have been approved by the State Medical Board as set forth in the physician's assistant application for registration:

1. Screen patients to aid the employing physician in determining need for further medical attention.

2. Review patient records to aid in determining health status.

3. Take patient histories; perform physical examinations; and identify normal and abnormal findings on histories, physical examinations, and commonly performed initial laboratory studies. Information collected is to be presented to the employing physician on the same day and prior to treatment.

4. Perform developmental screening examination on children as relating to nervous, motor, and mental functions.

5. Record pertinent patient data.

6. Make decisions regarding data gathering on patients being seen for the initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition. The physician's assistant will present the information collected to the employing physician on the same day and prior to treatment.

7. Prepare patient summaries for employing physician's patients only, which must be reviewed and countersigned by the employing physician.

8. Initiate requests for commonly performed initial laboratory studies.

9. Collect specimens for and perform commonly performed blood counts, urine analysis, stool analysis, and cultures using office kits.

10. Perform the following clinical procedures:
   a. Venipuncture.
   b. Intradermal tests.
   c. Electrocardiogram (not including interpretation).
   d. Care and suturing of minor lacerations after examination by the physician.
   e. Apply cast or splint under direction of the employing physician. Such application shall be made only after examination by the employing physician, and any necessary reduction by the employing physician.
   f. Application of dressings and bandages.
   g. Administration of medication and intravenous fluids (except blood) upon order of the employing physician.
   h. Removal of superficial foreign bodies after consultation with the employing physician and under his direction.
   i. Cardio-pulmonary resuscitation.
   j. Audiometry screening, to be presented to the employing physician.
   k. Routine visual screening, to be presented to the employing physician.
   l. Carry out aseptic and isolation techniques.
   m. Catherization of the urinary bladder.

11. Provide education regarding common patient problems.

(C) The physician's assistant may also perform any function which has been set forth in his application for registration and approved by the State Medical Board.

Prohibitions

(A) The physician's assistant shall perform only those functions set forth in the application of registration as approved by the State Medical Board. Further, those functions shall be performed only within the degree of supervision specified for that function in the application for registration as approved by the State Medical Board.

(B) The physician's assistant SHALL NOT perform functions or acts including, but not limited to, the following:

1. Make a diagnosis of a disease or ailment or the absence thereof independent of the employing physician.

2. Prescribe any treatment or a regimen thereof.

3. Prescribe or order medication; or sign or stamp prescriptions on behalf of the employing physician; or have prescription blanks available that have been presigned or stamped by the physician; or order the refilling of a prescription.

4. Sign a physician's name for the purpose of authenticating any prescriptions, orders, recordings; or sign the physician's name in any situation where the physician's signature gives the appearance of the physician's approval.

5. Supplant the employing physician in making visits outside the employing physician's office.

6. Initiate or change any orders on a patient's chart in hospitals, clinics, nursing homes or other places where patient charts are used.

7. Maintain an office separate from the offices of the employing physician.

8. Perform acupuncture.

9. Delegate a function assigned to him by the employing physician.

10. Perform endoscopic examinations or procedures or insert IUD's, unless the physician's assistant has been specifically authorized to do so by the State Medical Board.

11. Perform spinal punctures, bone marrow aspirations, and liver biopsies.

12. Admit patients to or release patients from a hospital.

13. Represent himself in any way as being able to perform beyond the specific functions set forth in the application of registration as approved by the State Medical Board.

(C) When a patient has not actually been seen and personally attended to by the employing physician, no professional fee for the physician's services shall be charged, and the fee for the services of the physician's assistant shall be specifically delineated as such on the patient's bill. The physician's assistant shall not independently charge for his services.

For What Reason Can a Registration Be Suspended or Revoked?

The Medical Board may suspend or revoke the registration of a physician's assistant for any of the following reasons:

(1) Failure to maintain employment under the physician or physicians submitting the statement of employment, and under the conditions under which the Board issued the certificate of registration;

(2) Failure to comply with the requirements of Chapter 4730, Revised Code, or any rules adopted by the Board;

(3) Inability to function as a physician's assistant, by reason of illness, drunkenness, excessive use of controlled substances, chemicals, or any other type of material, or as a result of a mental or physical condition;

(4) Conviction of an offense involving moral turpitude;

(5) Conviction of violation of any municipal, state, or

federal narcotic law; and/or

(6) Obtaining or attempting to obtain registration and certification by fraud or deception.

What Problems Commonly Occur in Applications for Registration?

Section 4730.02, Revised Code, states that a physician's assistant may provide services only to patients of the employing physician or physicians. The Medical Board has rejected several applications containing information revealing that the physician's assistant's services would be "provided to patients other than those of the physician or physicians to whom the assistant would be registered."

The State Medical Board has also taken the position that the employing physician or physicians shall not charge a professional fee for physician services if the patient has not actually been seen and personally attended to by an employing physician. This position is consistent with Section Seven of the AMA Code of Ethics.

How Does the New Law Affect Assistants Not Eligible to Register?

Not all assistants are eligible to register with the Medical Board. Many assistants trained in particular specialty areas such as surgical assistants, ophthalmic assistants, or urological assistants are not eligible to take the National Commission Examination. Others who might be eligible to take the examination may not qualify for registration because they are employed by a hospital or some other organization not constituting a group of physicians.

Assistants and extenders not registered must perform their services under the following provisions:

> Section 4731.34, Revised Code, provides in part as follows: "*A person shall be regarded as practicing medicine, surgery, podiatry, or midwifery, within the meaning of sections 4731.01 to 4731.60, inclusive, of the Revised Code,* who uses the words or letters, "Dr.", "Doctor", "Professor", "M.D.", "D.S.C.", "Pod.D.", "M.B.", or any other title in connection with his name which in any way represents him as engaged in the practice of medicine, surgery, podiatry, or midwifery, in any of its branches, or *who examines or diagnoses for compensation of any kind, or prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature, for the cure or relief of a wound, fracture or bodily injury, infirmity or disease.*
>
> Section 4131.41, Revised Code, provides in part as follows: "No person shall practice medicine or surgery, or any of its branches without a certificate from the State Medical Board; no person shall advertise or announce himself as a practitioner of medicine or surgery, or any of its branches, without a certificate from the board; no person not being a licensee shall open or conduct an office or other place for such practice without a certificate from the board; no person shall conduct an office in the name of some person who has a certificate to practice medicine or surgery, or any of its branches.
>
> All persons not holding a license from the State of Ohio Medical Board including Assistants and Extenders are persons prohibited from practicing medicine or surgery by the provisions of sections 4731.34 and 4731.41, Revised Code, as stated aforesaid. Such persons shall not admit anyone to a hospital or release anyone from a hospital, shall not diagnose or treat, and shall not prescribe drugs.
>
> Fully licensed physicians employing or using services of persons to assist them who are not licensed or registered by the State Medical Board are responsible for making certain that such persons are not practicing medicine or surgery and that services performed by such persons are performed in the immediate presence of and under the direct supervision of such duly licensed physicians.

Where are Primary Care Physician's Assistants Programs Offered in Ohio?

The following are addresses of training programs currently offered in Ohio:

Cincinnati Technical College
3420 Central Parkway
Cincinnati, Ohio 45223
Attn: Program Director

Cuyahoga Community College
Western Campus
11000 Pleasant Valley Road
Parma, Ohio 44130
Attn: Department of Allied Health

Kettering College of Medical Arts
3737 Southern Boulevard
Kettering, Ohio 45429
Attn: Physician's Assistant Program

Lake Erie College
391 West Washington Street
Painesville, Ohio 44077
Attn: Physician's Assistant Program

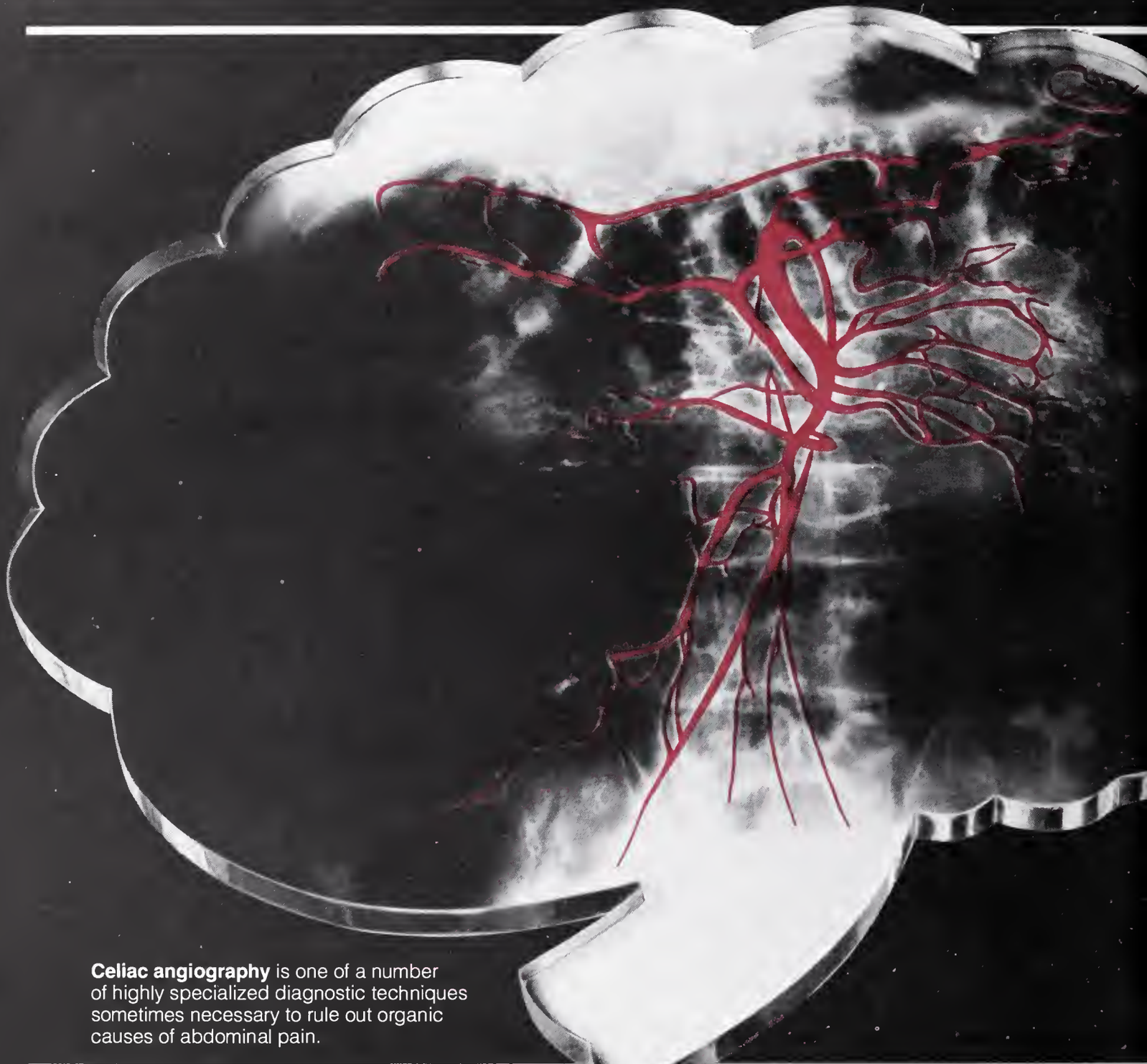
Questions

Questions regarding this article should be addressed to the Ohio State Medical Board, Suite 1006, 180 East Broad Street, Columbus, Ohio 43215. The telephone number is 614/466-3934.

Board members are Henry A. Crawford, M.D., Cleveland, president; Peter Lancione, M.D., Bellaire, vice-president; Anthony J. Ruppersburg, Jr., M.D., Columbus, secretary; Evelyn Cover, D.O., Columbus; Henry G. Cramblett, M.D., Columbus; Roland A. Gandy, Jr., M.D., Toledo; Jerauld D. Ferritto, D.P.M., Columbus; Walter H. Paulo, Canfield, consumer member; Sanford Press, M.D., Steubenville; and Norman O. Rothermich, M.D., Columbus.

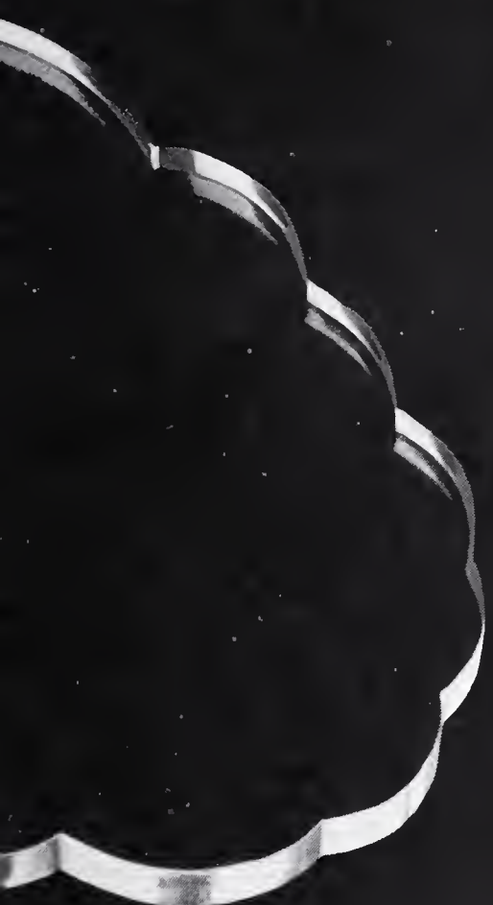
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Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacolcgic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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News *(continued from page 633)*

cording to the survey, a sizable majority of the population believes that increased government involvement will add to hospital costs without improving quality.

The Harris survey concluded: "It is evident that the American people are sharply divided on the two alternative approaches which have surfaced recently in Washington on how to control hospital costs and revenues. That the issue is a major one and the public is financially hurting is not hard to document. There is no doubt that people want to keep hospital and all other health costs in line. But there is a deep public aversion to federal promises of controlling costs. There is a preference for local community control working better than either the state or federal establishment."

Michael D. Bromberg, FAH National Director, stated: "The Federation is deeply involved in the intense debate surrounding the Administration's proposed cap on hospital revenues and has retained the Harris firm on an on-going basis. We need to know how the American people feel about hospital costs and legislative alternatives."

He also said hospitals must pursue full disclosure in order "to avoid being legislated into mediocrity." On this basis, the FAH is asking each of its 1,000 investor-owned hospitals to give every patient a letter which fully discloses the hospital's costs for the past two years. The Federation is also requesting that all other hospitals join in this effort. A copy of the letter, as well as the survey, is available from the Federation of American Hospitals, National Offices, Suite 310, 1101 17th St., N.W., Washington, D.C. 20036.

First Fully Designated HSA

The first fully designated health systems agency (HSA) in the country is the Health Systems Agency of Western New York, located in Buffalo. Fully designated status is conferred on a conditionally designated HSA when the Department of Health, Education, and Welfare approves the planning agency's "Annual Implementation Plan" and "Health Services Plan." The Buffalo HSA serves a population of about 1.7 million.

Health Care Chosen as High School Debate Topic

The National University Extension Association has chosen three health care topics for use by state forensic leagues. Each league will choose one of the topics for debate by local high schools during the 1977-1978 school year. The topics are malpractice, national health insurance, and national health planning. Currently, the AMA is preparing reference kits on the topics for use as background information.

ER Used for Routine Treatment

Two-thirds of the American Public regard the hospital emergency department as being interchangeable with a physician's office for general treatment capabilities, according to a survey made for the American Hospital Association. The survey, conducted by the Roper Organization, found that the main reason many people prefer the hospital emergency room for treatment is that they think hospitals have better treatment facilities than physicians' offices.

CME Video Clinics to Be Marketed by the AMA

The AMA will begin marketing Continuing Medical Education Video Clinics this fall. Aimed at physician use in the hospital or home setting, each clinic includes a program on color videotape (for use with a U-Matic ¾" videotape player), syllabus, tests, and instructions. Applicable for hour-for-hour Category I credit, the CME clinics will be available to hospitals and individual physicians for a nominal fee.

In the October *Journal*:
Scientific Article
With Category I CME Test

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Prior military medical experience is not essential although it would be helpful.

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P.O. Box 527
Scio, Ohio 43988
Phone: 614/945-6161 or
614/945-3301

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*In compliance with Res. 2-77, committee appointments are being made for one- and two-year terms. Such appointments already made are noted following the members' names.

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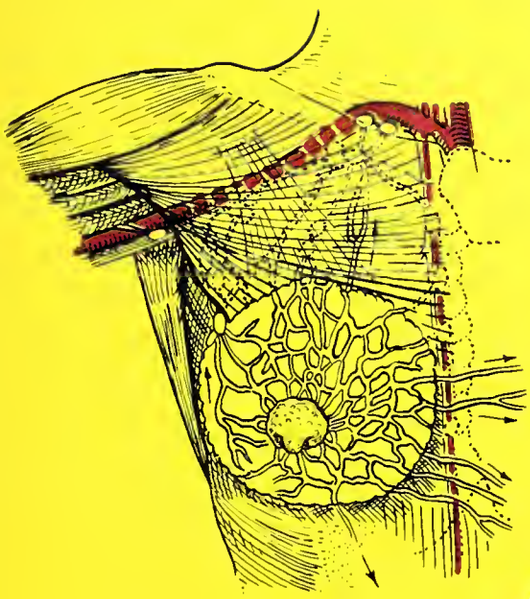
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Volume 73, Number 10

THE OHIO STATE Medical Journal

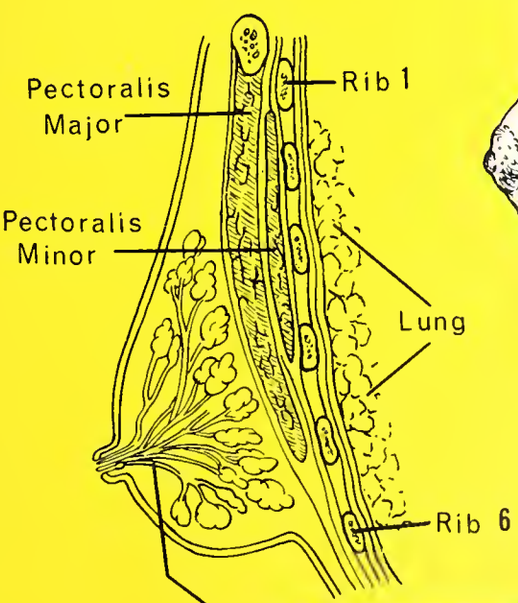


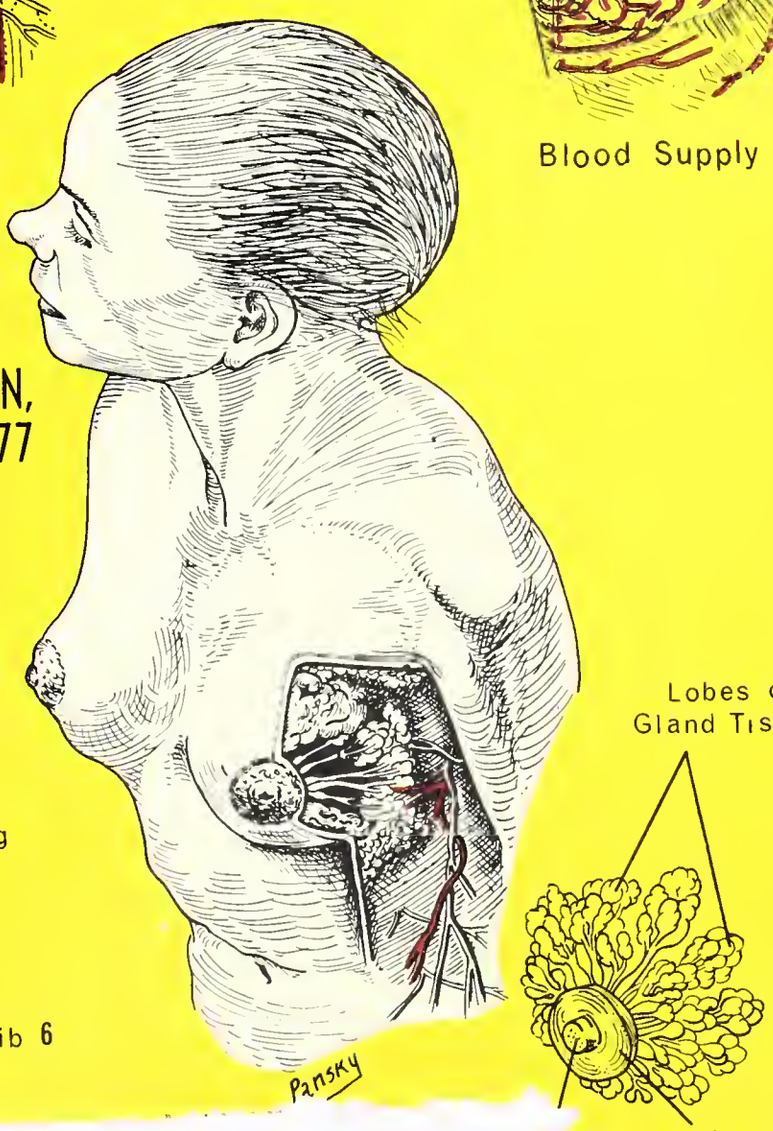
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Blood Supply

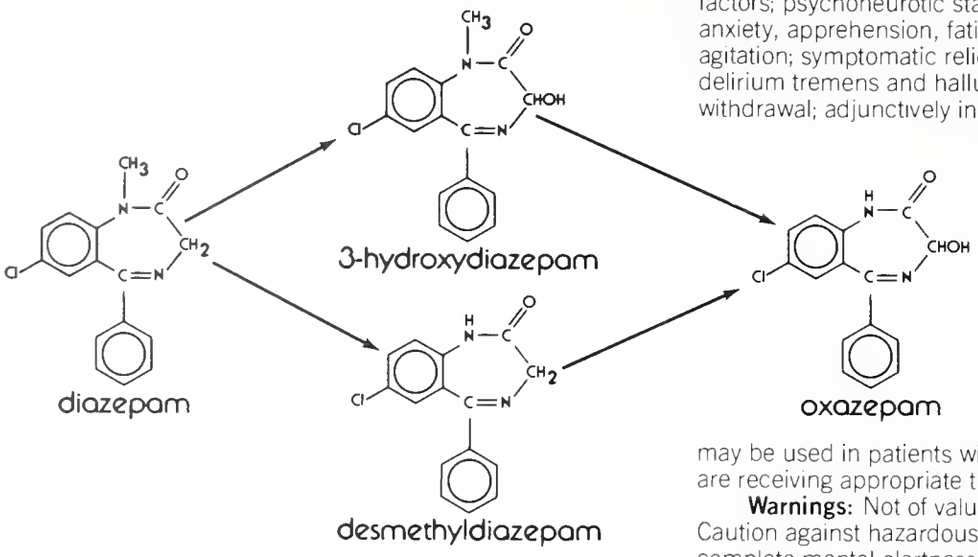
"CARCINOMA OF THE BREAST"
WITH CATEGORY I EXAMINATION,
PAGE 677





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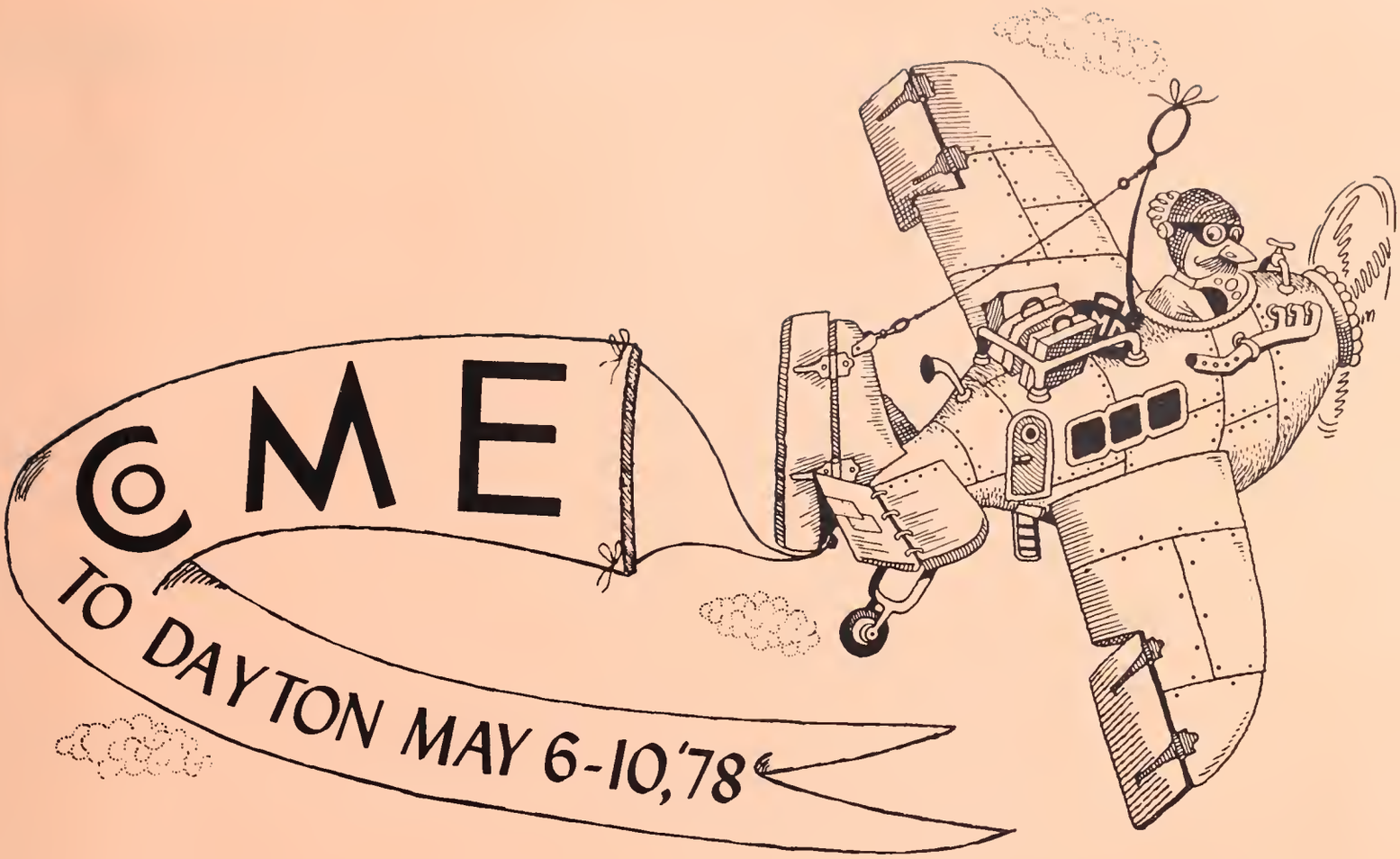
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Announcing . . .

The Ohio State Medical Journal Photographic Exhibit

The Ohio State Medical Journal is sponsoring a juried-and-judged photographic exhibit for members of the Ohio State Medical Association. The winning entries will receive awards at the 1978 OSMA Annual Meeting, where they also will be displayed. Winning entries may be published subsequently in *The Journal.*

Photographs may be entered in two divisions: (1) BLACK AND WHITE and (2) COLOR. Each division has eight categories: (1) Action, (2) Still, (3) Animals, (4) Scenic, (5) Portraits, (6) Scientific, (7) Special Effects, and (8) Miscellaneous.

Entries must be in print form (minimum size 8″ x 10″; maximum size 2′ x 3′) and must be previously unpublished. Right to publish the photograph must be given to *The Journal* at the time the photograph is entered in the exhibit. The print submitted for the exhibit will not be returned. Entries must be postmarked no later than February 15, 1978.

An OSMA member may submit as many entries as he/she wishes. Each entry must be accompanied by an entry form and a $5 entry fee.

Checks should be made payable to The Ohio State Medical Journal.

THE OHIO STATE MEDICAL JOURNAL PHOTOGRAPHIC EXHIBIT
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STREET_____

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Still____ Scenic____ Scientific____ Miscellaneous____

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COVER: This illustration of the female breast was designed especially for *The Journal* by Ben Pansky, Ph.D., M.D., Professor of Anatomy and Director of the Baccalaureate Degree Program in Nursing at the Medical College of Ohio, Toledo. Dr. Pansky is also author and illustrator of *A Review of Gross Anatomy* and *Dynamic Anatomy and Physiology* (both MacMillan Publishing Co., Inc.) and *A Functional Approach to NeuroAnatomy* (McGraw-Hill Book Publishers). This is Dr. Pansky's second *Journal* cover, having supplied the art for the January 1976 cover (Vol. 72, No. 1). Turn to page 677 for the article "Carcinoma of the Breast" and the accompanying Category I examination.

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THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

We are writing this letter concerning the article published on page 440 of the July 1977* issue of *The Ohio State Medical Journal.* Dr. David Massa, an anesthesiologist, poses the question "to what extent should today's anesthesiologists be involved in providing their skills for the pregnant women in their immediate area?" After a review of 25 years experience, the statement is made "Since January 1975, obstetric anesthesia for vaginal deliveries in this community has been managed entirely by obstetricians— and managed very well." The implications from this article are that anesthesiologists should not concern themselves with providing pain relief for vaginal delivery and that there is no place for general anesthesia. Since we have a residency training program for anesthesiologists, and strongly encourage the application of these skills to all who need it, we cannot agree that anesthesiologists should withdraw from this area of practice. We are of the option that the obstetrician should provide the anesthesia where he can as long as the patient is adequately and safely monitored during and following its administration.

We encourage natural childbirth techniques, but make available pain-relieving techniques when they become necessary.

Anesthesiologists should not encourage the use of anesthesia for vaginal delivery where the patient is quite capable of managing without, but where suffering is severe or fetal distress is threatened, anesthesiologists should not be reluctant to provide their services.

Sincerely yours,

s/D. W. Eastwood, M.D.
Professor of Anesthesiology
Case Western Reserve University
School of Medicine

s/Irvin R. Merkatz, M.D.
Professor of OB/GYN
Case Western Reserve University
School of Medicine

*Vol. 73, No. 7, p. 440, 1977.

* * * * *

To the Editor:

The letter of Doctors Eastwood and Merkatz has been gratefully received.

It is a joy to be in total agreement with such excellent physicians.

We remain, as always, on call when needed.

Sincerely,

s/David J. Massa, M.D.
Anesthesia Associates of Mansfield, Inc.
Mansfield, Ohio

To the Editor:

This letter is in reference to Dr. James C. Good's article, "Does Breast Milk Alone Prevent Iron Deficiency Anemia?," in the August issue of *The Ohio State Medical Journal.** Dr. Good has demonstrated what most of us pediatricians have held to be true in regard to the nutritional aspects of breast feeding, that is, breast-fed babies do not develop iron deficiency anemia. There are a few comments that I wish to make:

1. While the life span of the red blood cell is about 120 days in adults, the life span in newborns is less, about 80 days. This item plus a decrease in bone marrow erythropoietic activity, an increase in the rate of hemolysis, and hemodilation due to a rapid expansion of blood volume when the infant is growing, lead to a physiologic anemia at six to eight weeks of age with hemoglobin levels as low as 9.5 to 10 gm/100 ml in full-term infants. These are non-pathologic and do not require therapy or blood transfusion.[1]

2. The risk of iron deficiency is greatest when neonatal iron stores have been depleted, which is about two months in pre-term infants and after four to six months in full-term infants. Hemoglobin values done at these ages would reflect the iron stores available.[2]

3. Recent studies have indicated that breast-fed infants during the first to seven months of life attain greater iron stores than do infants fed a cow milk formula. Breast-fed infants were also found to absorb an average of 49 percent of a trace dose of extrinsic iron administered during a breast feeding in contrast to about 10 percent reported from cow milk under similar conditions. Most foods, including cow milk, inhibit the absorption of a test dose of iron. This is not true with breast milk, as it appears that iron in breast-fed babies is unusually well-absorbed.[3]

Sincerely,

s/Leonard J. Janchar, M.D.
The Frederick C. Smith Clinic
Marion, Ohio

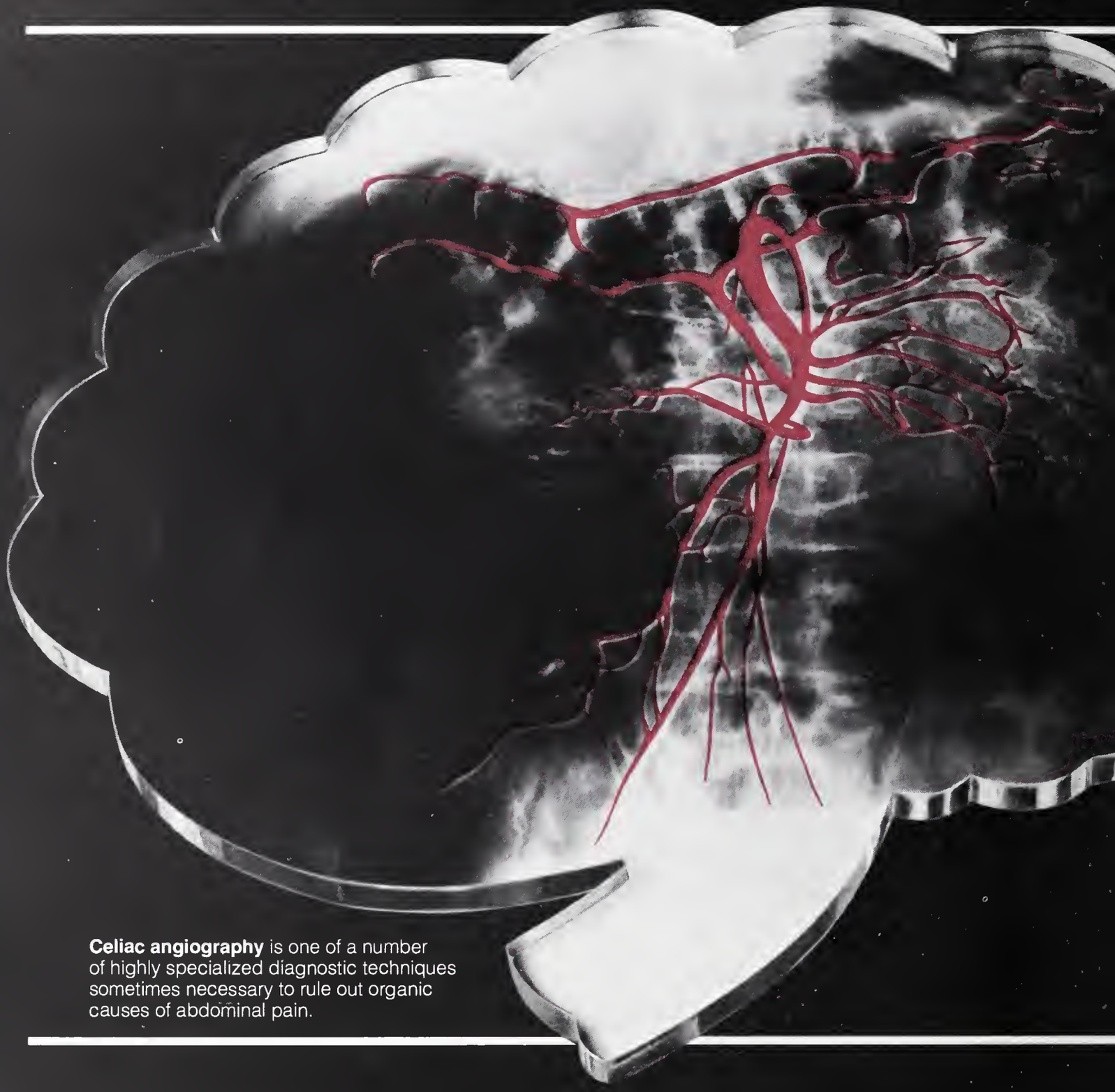
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1. O'Brien RT, Pearson HA: Physiologic anemia of the newborn infant. *Pediatrics* **79**:132-138, 1971.
2. Comm on Nutrition: Iron supplementation for infants. *Pediatrics* 58:765-768, 1977.
3. Saarinen UM, Siimes MA, et al: Iron absorption in infants: high bioavailability of breast milk iron as indicated by the extrinsic tag method of iron absorption and by the concentration of serum ferritin. *J Pediatr* **91**:36-39, 1977.

*Vol. 72 No. 8, p. 562, 1977.

The Journal *welcomes reader reaction to published material. Address correspondence: Editor,* **Ohio State Medical Journal,** *600 South High Street, Columbus, Ohio 43215.*

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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

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AMA Education and Research Foundation Gears Up for 1977 Campaign

Robert D. Clinger, OSMA Assoc. Executive Director

Physicians and Auxilians, you may recall that last year *The Journal* carried an article that stated: "You should be proud of your contributions to the American Medical Association Education and Research Foundation (AMA-ERF) during 1975."

You should be doubly proud for 1976! While the donations on a nationwide basis dropped by $94,143.10 from 1975 to 1976, donations to Ohio's six medical schools increased. As a result of your generosity, Ohio's schools shared a 6 percent gain from $62,742.50 in 1975 to $66,-509.37 in 1976.

Philip Hardymon, M.D., Columbus, Chairman of the Ohio AMA-ERF Committee, which includes the 12 District Councilors of OSMA, gives the lion's share of credit for Ohio's excellent showing to the OSMA Auxiliary. He cited their enthusiasm and aggressiveness as making the difference between mediocrity and excellence.

Can the 1977 campaign be as successful? Can contributions again show a major increase? Why not! Your dollars play a vital role in the future of the medical profession.

Dr. Hardymon pointed out that large numbers of outstanding medical students, interns, and residents have only one major barrier to hurdle before taking their place on the front line of health care delivery. That barrier is the **lack of adequate funding** for the remainder of their education.

Dr. Hardymon cited the following:

1. A total of 267 loans amounting to $375,800 were made to medical students, interns, and residents in Ohio during 1976. This represents a considerable increase over the 165 loans amounting to $252,600 in 1975.

2. Since the loan program began in 1962, Ohio medical students, interns, and residents have received 2,636 loans amounting to $3,101,350.

3. Total contributions to AMA-ERF throughout the nation during 1976 (distributed to medical schools in 1977) amounted to $1,180,856.73. This represents a **drop** of $94,143.10 nationwide from the 1975 total.

Dr. Hardymon presented 1977 checks to the deans of Ohio medical schools during the first session of the OSMA House of Delegates held May 15, 1977 in Columbus. Amounts presented to each school are as follows: The University of Cincinnati College of Medicine— $18,638.87; Case Western Reserve School of Medicine— $11,992; Medical College of Ohio at Toledo— $5,496.07; The Ohio State University College of Medicine— $17,-221.18; Northeastern Ohio Universities College of Medicine— $7,868.04; and Wright State University School of Medicine— $5,493.21.

All this has been done by a private sector of the economy without government subsidy. This enviable record can be maintained with the help of Ohio physicians. Here are answers to some questions you may have concerning the Student Loan Guarantee Fund.

Did you know that through the Student Loan Guarantee Fund, the struggling medical student may receive direct financial aid?

Did you know that with increasing inflation, it now costs more than $5,000 per year to attend medical school?

Did you know that your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each $1 you give, another $12.50 will be put to work in loans made by a commercial bank; and as these loans are repaid, the money is reactivated to help other students.

Did you know that the accepted applicant becomes eligible for medical education loans of up to $1,500 a year? Additional applications may be approved each year so that a maximum of $10,000 can be borrowed over a seven-year period.

Did you know that the borrower pays only the established interest rate during his training and has ten years after completion of training to repay the principal?

How do you contribute? Shortly after you receive this issue of *The Journal,* you will receive a letter from Dr. Hardymon and a special AMA-ERF return envelope. The inside of the envelope includes space for your choice of medical school to receive your contribution, choice of category for your contribution, and the amount of your contribution. The pre-addressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

In summary, the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine. AMA-ERF functions as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

You, Doctor, can become an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a tax deductible contribution of $125 would guarantee a medical student's loan for one year.

If you have questions or need further information concerning the 1977 AMA-ERF campaign, don't hesitate to contact the OSMA office at 600 South High Street, Columbus 43215. Telephone 614/228-6971.

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THE OHIO STATE Medical Association Clinical and Scientific

Regional Enteritis

A Review of the Literature

Sheldon C. Binder, M.D.
Bertram Katz, M.D.

The clinical management of regional enteritis, a chronic disease of unknown etiology affecting young adults, is reviewed. Until specific therapy becomes available, the patient should be managed as a cooperative effort of internist and surgeon who, exercising good clinical judgment, can allow the patient to lead a relatively normal life.

REGIONAL ENTERITIS became a clinically recognized entity in 1932 when Crohn reported 13 cases. It is a disease of obscure etiology for which there is no specific treatment.

The disease affects young adults mainly, with clinical manifestations appearing initially between the second and fourth decades of life in about 80 percent of cases.[1] The maximum incidence is in the third decade, with 65 percent to 70 percent of cases appearing before 31 years of age.[2,3] Only 5 percent to 10 percent of cases occur in individuals over 50 years old.[2,4] The disease appears more frequently in middle or high income groups and, therefore, is found more often in patients in private rather than charity hospitals. Negroes rarely are affected. The disease is found more often in Jews of Western European extraction.[5]

Pathophysiology

The disease usually is limited to the terminal portion of the ileum in its initial and recurrent attacks. However, it may involve any portion of the gastrointestinal tract from the stomach to the rectum; and recently, sporadic cases have been reported in which the esophagus has been involved. The earliest microscopic changes are submucosal and subserosal edema.[6] A lymphadenoid hyperplasia occurs which leads to superficial mucosal ulceration in a mesenteric border location. An inflammatory infiltrate in the submucosa and subserosa occurs, with plasma cells, lymphocytes, and eosinophiles predominating. A nodular, granulomatous change occurs in the lymphoid nodules of the small intestinal wall, with giant cells becoming prominent. The same changes occur in the regional lymph nodes. The submucosal and subserosal edema and inflammation progress to a granulomatous, necrotizing, ulcerating, and cicatrizing process which frequently is accompanied by chronic perforations with fistulae. The process progresses to fibrosis and cicatricial stenosis of the intestine.

Although the terminal ileum is involved primarily by the disease, the cecum and right colon become involved by direct continuity in 10 percent to 55 percent of cases.[1,2,7-10] The colon becomes involved in skip areas or with more extensive disease in 5 percent to 40 percent of cases.[2,4,6,10-14] Skip areas in the small intestine occur in 12 percent to 35 percent of cases.[4,6,8] The entire small intestine is involved in about 15 percent to 20 percent of cases,[4,5] the stomach or duodenum in about 5 percent of cases.[1] In about 60 percent of the patients, follow-up with serial radiologic examination will show extension of disease to previously unaffected segments of the small or large intestine.[1] In most cases, such extension is first observed after definitive surgical therapy, with the new areas of involvement most commonly occurring in the small intestine at the site of anastomosis to the colon; but proximal skip areas are also observed.[15] Extension is demonstrable in about 10 percent of cases, either in continuity with the original disease or in proximal skip areas before surgical therapy. Fistulization into an adjacent

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viscus usually does not spread regional enteritis into that viscus.[15]

Although in most series there is an equal sex distribution in occurrence of the disease, females tend to be younger at the onset of disease and have a shorter clinical course before developing complications requiring surgical intervention. They tend to fare worse with the disease and require second or multiple operations more frequently than male patients.[2,4,12,16,17]

Clinical course of the disease is either progressive or marked by relapses and remissions. Chronicity is demonstrated by multiple hospital admission of patients with regional enteritis and the multiple surgical procedures that are performed for the disease. In Banks' series,[1] there was an average of 3.8 admissions to hospital over an average follow-up interval of 15 years; 69 percent of his 168 patients required two or more hospital admissions.

Acute Regional Enteritis Syndrome

In 10 percent to 20 percent of various reported series,[1,17] patients present with a syndrome erroneously diagnosed as acute appendicitis or as acute tubo-ovarian disease, with a rapid onset of pain in the right-lower quadrant or the lower abdomen lasting from a few hours to a few days, associated with fever, leukocytosis, and physical signs of localized peritoneal irritation but without clinical, radiologic, or operative evidence of long-standing regional enteritis. Appendectomy usually is performed in these cases. In Gump's review of the literature, only 35 cases (9 percent) of 396 cases of this "acute regional enteritis syndrome" progressed to the chronic form of regional enteritis.[18] It appears, therefore, that the acute regional enteritis syndrome has little relation to the chronic disease. However, it is important to distinguish the acute regional enteritis syndrome from the chronic disease with acute exacerbation in determining therapy. When chronic regional enteritis is discovered at operation performed for erroneously diagnosed acute appendicitis, it is reasonable — and probably the judgment of choice — to resect the involved portion of intestine; radical resection would be needless in 91 percent of the cases of the acute regional enteritis syndrome.

The Appendectomy Controversy

There has long been controversy concerning the advisability of performing appendectomy in the face of the acute regional enteritis syndrome or when chronic regional enteritis is diagnosed for the first time at laparotomy. Although Catell and Barber reported 33 percent and 39 percent rates of fistulization after appendectomy,[6,12] the incidence has been reported at between nil and 14 percent in more recent series.[1,3,10,14,19,20] Fistulae and abscesses, when they do occur, originate from the diseased ileum and not from the appendiceal stump.[15,20,21] They are related to the laparotomy itself rather than the appendectomy. A cogent argument for performing incidental appendectomy when laparotomy reveals acute or subacute regional enteritis is the elimination of acute appendicitis from the differential diagnosis in future episodes of acute, right-lower-quadrant pain. It is generally agreed now by most surgeons that incidental appendectomy in the presence of regional enteritis is a relatively innocuous procedure if the disease is confined to the small bowel and does not involve the cecum. When the cecum is involved, however, either definitive surgery for the regional enteritis should be performed or the laparotomy should be terminated without appendectomy.

Diagnosis

The usual symptoms of regional enteritis are abdominal colic, pain in the right-lower quadrant of the abdomen, vomiting, fever, and diarrhea. These symptoms progress to weight loss, weakness, chronic gastrointestinal bleeding, multiple factor anemias, protein and various vitamin deficiencies, and perianal disease.[4,12,16,22] Eventually, during the course of the progressive disease or during exacerbations of the relapsing disease, between 75 percent and 90 percent of patients will undergo a surgical operation.

The clinical diagnosis usually is confirmed by barium enema examination, which reveals stenosis, loss of mucosal pattern, and rigidity of the terminal ileum — the classical "string sign." On small-bowel upper gastrointestinal series, there is an increase in small bowel motility with segmentation of barium and irregularly narrowed outlines of the small intestine.[5,23] Separation of intestinal loops may be apparent; and displacement of small intestine by intra-abdominal phlegmon or abscess may appear. Internal fistulae will be apparent, and the signs of chronic intestinal obstruction will be obvious. The ileum is involved in about 98 percent of cases; therefore, if the terminal ileum appears normal following barium enema, a diagnosis of regional enteritis is remote.[5]

Extraintestinal manifestations of regional enteritis may be part of, or even dominate, the clinical picture.[2] Liver dysfunction, especially in long-standing, severe, and extensive disease, occurs in about 24 percent of cases; arthritis in 5 percent; erythema nodosum or multiforme in 3.5 percent; cholelithiasis in 7 percent; urinary calculi in 5 percent; and peptic ulcer disease in 12 percent. Perianal disease may dominate the clinical manifestations of the disease.

Clinical Therapy

The initial treatment of regional enteritis is a nonspecific medical regimen consisting of a diet low in fat and residue and high in protein, carbohydrate, and vitamins. Even if required for long periods of time, an elemental diet may effect remission even in severe exacerbations of the disease. Total parenteral nutrition may be necessary. Rest and mild sedatives are used. Antispasmotic or anticholinergic drugs are employed to control diarrhea. Azulfidine is the initial drug of choice except in severe primary cases or severe relapses of chronic disease. Corticosteroids are used in the severe forms of the disease or in those unresponsive to Azulfidine. Both Azulfidine® and

corticosteroids will effect remissions in about 75 percent of patients, even during severe episodes.[2] Their long-term use may reduce the incidence and severity of future exacerbations; but the long-term use of corticosteroids is of only dubious efficacy, and its own risk of complications accompanies it. The use of corticosteroids may increase the risk of and mask the physical signs of intestinal perforation or fistula formation. Some investigations have reported increased mortality rates in the disease, whether treated medically or surgically. Corticosteroid therapy is contraindicated in the face of internal fistulae because of an increased risk of free perforation associated with their use. Initial clinical improvement with Azulfidine or corticosteroids does not correlate with subsequent prevention of relapses.[2] They do not effect any discernible improvement in the overall prognosis of the disease; and they essentially never effect a permanent "cure."

Azathioprine has been used experimentally in the management of regional enteritis;[17] and several reports of dramatic healing of fistulae have appeared in the literature. However, in general, the ability of Imuran® to induce remissions is no better than that of corticosteroids.

Most surgeons and gastroenterologists agree that there is little indication for elective surgery in the early florid phases of the disease unless there are severe complications. However, undue delay of surgical intervention can allow the extension of disease to adjacent viscera. Septic complications have been known to escalate a relatively simple surgical problem into a formidable and hazardous undertaking. Although surgical therapy does not guarantee cure of the disease, elective surgery may be safer than the dangers of long-term drug therapy. The physician should not persist in medical management to the point where septic complications and severe metabolic deterioration of the patient make the patient a prohibitive operative risk.

Indications for Surgical Intervention

Most patients are operated on for disease that proves intractable to medical management or because of local complications of the disease.[1,4,6,8,12,16,18,22,24] There is some correlation between the extent of involvement of the intestine, the presence of skip areas, the rapidity and severity of clinical progression of the disease, and the incidence of complications requiring surgical intervention.[2] Young patients are more likely to have a fulminating clinical course than are patients who develop the disease at an older age. Frequently, the complications of the disease are multiple in the same patient.

The usually accepted indications for surgical intervention are:

1. *Intractability to Medical Therapy.* This may include a decline in the general condition of the patient both physically and mentally, severe diarrhea with weight loss and nutritional disturbances, and retarded physical or mental development in younger patients. In various series, intractability accounts for 10 percent to 25 percent of the surgery performed in these cases.

2. *Intestinal Obstruction.* Though conservative medical management with intestinal intubation, drugs, an elemental diet, or total parenteral nutrition may effect remission in the edema phase of an acute exacerbation of regional enteritis, it cannot be expected to relieve the obstruction caused by a severe, chronic cicatrization of the intestine. Intestinal obstruction accounts for between 25 percent and 90 percent of the cases requiring surgery.

3. *Abdominal Mass.* This usually indicates intestinal perforation with abscess formation. It is the indication for surgery in 10 percent to 25 percent of cases.

4. *Internal or External Fistulae.* These may be enteroenteric, enterovesical, enterovaginal, or enterocutaneous. Enterocutaneous fistulae may occur spontaneously, but are more common in patients who have had an operation. They occur either early as a postoperative complication or late as an indication of recurrent disease.[24] Fistulization is the indication for surgery in between 5 percent to 50 percent of cases.

5. *Hemorrhage.* Is an infrequent cause for surgical intervention, in the range of 1 percent to 3 percent in most series.

6. *Severe Perianal Disease.* May dictate surgical intervention especially when it destroys the anal sphincter mechanism and results in fecal incontinence.

7. *Free Perforation.* This rarely is an indication for surgery. Only about 52 documented cases have been reported.[25]

A review of the literature reveals that between 70 percent and 90 percent of patients with regional enteritis eventually come to surgical therapy. The time interval from the onset of symptoms to the first major operation is less than one year for between 50 percent and 75 percent of those who are operated on. Although conservative management usually is the initial therapy for the disease, it has little to offer in the management of the local complications that develop in most cases of regional enteritis. On the other hand, for patients with the diffuse form of disease, it will have to remain the treatment of choice until intestinal transplantation becomes a clinical reality.

Surgical Therapy

In most series in which intestinal bypass operations have been performed without exclusion of the involved segment, there have been high rates of persistence of active disease, local complications in the excluded bowel, and high rates of early recurrence requiring subsequent surgical operations (two- to three-fold increased risk over resectional surgery). Thus, except in very unusual circumstances, in-continuity bypass should be abandoned as a definitive form of surgical therapy for regional enteritis.[2,15,20,26]

At the present time, the two accepted methods of surgical treatment are bypass with exclusion and resection of the diseased portion of intestine. There is no data to indicate that the malfunctioning, diseased, small intestine can recover to the point that it can be reinserted as a useful segment into the intestinal tract.[6] Furthermore, 11 of 36 reported cases of adenocarcinoma complicating

chronic regional enteritis have occured in surgically bypassed segments of the small intestine.[27-29] Most surgeons, therefore, prefer resection to exclusional bypass whenever it is technically possible. In recent series, both operations show an operative mortality rate of 2.4 percent to 3.6 percent, even in second operations for recurrence.[4,6,12,13,16.17,20,22,30]

The small intestine should be divided 10 cm to 12 cm proximal to the grossly involved segment, with confirmation of free-resection margins by frozen-section, pathologic examination. Only those lymph nodes which can be excised without interrupting the blood supply to the normal bowel are removed. End-to-end anastomosis after resection is the preferred method of reestablishing intestinal continuity. Both for technical reasons and to reduce the incidence of recurrence, the cecum or right colon should be resected with the involved terminal ileum.

There is a high incidence of enterocutaneous fistulae after laparotomy without resection of the diseased intestine.[24] This is a cogent argument for primary resection when chronic regional enteritis is diagnosed first at a laparotomy for another diagnosis. For intra-abdominal abscesses secondary to local perforation of regional enteritis, incision and drainage of the abscess almost invariably leads to persistent fistulae. Therefore, the treatment of choice is resection of the diseased intestine, if possible; otherwise, incision and drainage of the abscess and exclusional bypass of the diseased bowel should be performed.[15,20,24] For free perforation of the intestine, resection of the diseased bowel with double-barrel, cutaneous enterostomy, and subsequent reestablishment of intestinal continuity avoids the risk of anastomosis in the presence of peritonitis. Using this method of management, there have been no deaths in the eight cases reported in the literature. An alternative is primary resection and anastomosis; but 3 of the reported 20 cases treated by this method have died of anastomotic disruption.[25] Fistulae should be managed by resection of the involved intestine and fistula.[15,24] When ileosigmoid fistulae are encountered, the communication in the sigmoid may be closed if the sigmoid wall is not involved grossly by granulomatous colitis and the hole in the sigmoid is small.[15] Duodenal, regional enteritis is best managed by gastroenterostomy. If cholelithiasis is present,[7] the judgment of the surgeon will determine the safety of performing concomitant cholecystectomy. The management of concomitant, active, peptic ulcer also is a matter of clinical judgment.

Proximal skip areas are resected only if they are causing obstruction or fistulae. In some cases, skip areas present initially will regress spontaneously after the more severely involved distal ileum is resected.[6]

Bypass of the diseased intestine, if performed, should be done only with exclusion of the involved segment of bowel.

Prognosis Following Surgery

In the overall clinical course of patients with regional enteritis, the years on conservative medical therapy alone are more likely to be marred by symptomatic disease than are the years after surgical therapy.[30] However, recurrent disease is distressingly common after surgical therapy.

Recurrences of regional enteritis occur almost without exception in the area of intestine proximal to the anastomosis performed at the time of the original definitive surgery.[4,12,16] However, it sometimes is difficult to determine clinically if and when a recurrence has occurred since diarrhea alone, especially after sacrifice of the ileocecal valve, does not necessarily mean recurrent disease. The same radiologic diagnostic methods are employed as with the primary disease. The decision concerning medical versus surgical therapy for recurrent disease involves the same judgments as those employed for the decision for the first operation. In a disease in which the surgery may involve multiple resections of small intestine, the surgeon sometimes is hesitant to embark upon repeated resections of intestine. It must be realized, however, in this disease that further activity of the disease itself is a more important cause of nutritional failure than is loss of small bowel. Nutritional failure should not be a major problem until the patient is left with five feet or less of small intestine.[31] At present, the use of reversed segments of intestine is still in an experimental stage; and its indications and value are not yet firmly established.

It is difficult to assess the comparative merits of resectional surgery versus exclusional bypass since the selection of patients influences the results obtained by various authors; bypass operations frequently are reserved for unusually complicated cases or for debilitated patients who generally have a poorer prognosis. Although most surgeons favor resection and report lower recurrence rates than after bypass, many investigators have found that the type of operation, the length of normal bowel removed proximal to the disease, or the extent of regional lymphadenectomy have no significant bearing on the incidence of recurrence.[1,19,23] The extent of bowel involved does have a bearing on the risk of recurrence, with an increased likelihood of recurrence the longer the segment of bowel involved, and an increased risk of recurrence when skip areas are involved more proximally in the small intestine. Involvement of the colon along with the small intestine, ie, granulomatous ileocolitis, generally is considered a more aggressive disease and more likely to recur than is regional enteritis involving only the small intestine. There is some concensus that the incidence of recurrence is greater in persons who develop the disease at a younger age. In Crohn's series,[3] with an overall recurrence rate of 30 percent, only 12 percent of patients over age 50 years developed recurrence after surgery. In Atwell's series, with an overall recurrence rate of 50 percent, those patients who had the onset of their disease under age 15 years had a 93 percent postoperative recurrence rate.[3] It is thought, though not universally, that if recurrence does occur and a second operation is necessary, further recurrence is highly probable.

Although recurrences do occur at long intervals postoperatively, 50 percent of patients who develop them

Recurrence Rates After Definitive Therapy

Author	Year	Reference No.	No. of Patients	After First Operation %	After Subsequent Operations Operation	%	Comment
Van Patter, et al	1958	23	402	62	Second Third	81 89	
Diefer	1958	31	42	34			
Jackson	1958	8	126	55			
Crohn	1959	13	400	30			
Meyers, et al	1959	14	100	43			
Barber, et al	1962	6	257	19	Second Third	31 27	
Barber, et al	1962	36	82	27	Second Third	32 29	
Atwell, et al	1965	3	172	50			
Schofield	1965	10	156	18			
Colcock	1967	4	375	37	Second Third	46 54	
Gump, et al	1967	37	117	46	Second	40	
Lennard-Jones	1967	38	78	50			
Banks, et al	1969	1	118	60			
Brill, et al	1969	11	35	70			
Krause, et al	1971	22	168	39	Second Third	43 20	
Mathews, et al	1971	39	68	42			Average 2.3 operations per patient
Alexander-Williams, et al	1972	26	89	48	Second	100	
Grogono and Parks	1972	23	152	16	Second	60	Recurrence defined as reoperated
Gump, et al	1972	19	117	45			
Kyle	1972	17	—	18			
DeDombal, et al	1972	30	415	34	Second Third	20 31	Recurrence defined as reoperated
Arvanitakis and Manier	1973	2	75	53			Average 2.8 operations per patient
Hardin and Freisen	1973	7	40	17			
Farmer, et al	1975	40	615	27			Recurrence defined as reoperated

do so within one year; and 80 percent of recurrences are within five years of the time of the initial, definitive surgery.[1,11] Patients who have been clinically free of disease for more than five years, therefore, have an excellent chance of permanent clinical arrest of their disease. In his reports on long-term follow-up of patients operated on for regional enteritis, DeDombal has separated two forms of the disease.[30,32] Fifty-one percent of cases have a rapid clinical course leading to early operation and associated with a high rate of early (first one to two years) postoperative recurrence, poor subsequent prognosis, and frequent need for multiple surgical interventions; 17 percent of cases have a slower developing disease leading to surgery later in its course, associated with a lower risk of late (5 to 15 years) postoperative recurrence, and good, subsequent prognosis with infrequent need for multiple operations.

Rate of recurrence following definitive, surgical therapy has been reported at between 18 percent and 70 percent in various series; and the incidence of requiring a second operation at between 15 percent and 54 percent. (See Table.) As an approximation, it may be stated that half of all patients will develop recurrence after their first definitive operation, and half of these will require a second operation. After the second and subsequent operations, half will develop recurrence again, and half of these will require additional surgery. Even when recurrence occurs postoperatively, the medical management of the

patient frequently is easier than before the initial operation. In most series, the second operation seldom was the start of a progressive clinical deterioration; even after recurrences and reoperations, between 75 percent and 90 percent of patients are in good health at time of follow-up.[20,30,32,33] Therefore, even though recurrence rates are high in most series, the salvage rates after each additional surgical procedure generally are significant. This is to be contrasted with the morbidity and chronic debilitation of patients treated medically and denied surgical therapy for their disease, with a "medical salvage rate" of only 10 percent of patients who never undergo surgery.[1,16] Therefore, though not advocating earlier and more aggressive surgical therapy for regional enteritis, the clinician should not assume a poor prognosis for the patient suffering from this disease entity.

Anal Complications

Between 9 percent and 30 percent of patients with regional enteritis develop perianal complications,[1,3,4,12,13,15,16,20,34] especially those with granulomatous involvement of the colon and/or rectum. Of course, abscesses must be incised and drained. However, when treated with conventionel surgical techniques, the perianal fissures and fistulae heal slowly, may exacerbate an indolent, septic process, and may lead to multiple operations and, ultimately, to an incompetent anal sphincter. Since perianal complications respond so poorly to local therapy until the primary disease is brought under control, surgical therapy should be deferred, if possible, until the active, regional enteritis can be relieved.

Pregnancy and Regional Enteritis

Patients with regional enteritis may be rendered temporarily infertile by the activity of their bowel complaints; but the disease has no adverse effect during pregnancy on either mother or child. Of 60 pregnancies in 40 women in DeDombal's series,[35] most went to term normally. If anything, the regional enteritis tended to improve during pregnancy. After delivery, however, 40 percent of patients suffered a relapse of their enteritis. Therefore, it is suggested that corticosteroid therapy logically may be instituted postpartum to prevent relapse.

Carcinoma Complicating Regional Enteritis

Thirty-six cases of adenocarcinoma of the small intestine complicating regional enteritis have been reported.[27-29] Only 14 percent of these cases were diagnosed preoperatively or intraoperatively; in the majority of them, the diagnosis of the carcinoma was not made until pathologic examination of the resected bowel. The average duration of regional enteritis before diagnosis of carcinoma has been 14 years. Average age of patients with cancer-complicating, regional enteritis has been ten years less than with primary adenocarcinoma of the small intestine (44 years vs 55 years of age); and the ilium has been the most frequent site, as opposed to the duodenal predominance of primary carcinoma of the small intestine. The usual clinical presentation has been rapid physical deterioration, progressive anemia, and sudden onset of intestinal obstruction in a patient with previously well-controlled or long-quiescent, regional enteritis. Prognosis for adenocarcinoma complicating regional enteritis has been dismal, with a five-year survival rate of 3.7 percent and an average survival of six to eight months, as opposed to primary carcinoma of the small intestine, with a five-year survival rate of 20 percent and an average survival of 30 months.

Conclusions

Until the etiology of regional enteritis has been determined and more specific therapy becomes available, the patient affected with the disease should be managed as a team effort of internist and surgeon. The surgeon should be conservative in recommending surgical intervention; but the internist must be aggressive in recommending an operation when the disease fails to respond to medical therapy. With good clinical judgment on the part of their physicians, the majority of patients will lead a productive and relatively comfortable existence.

Generic and Trade Name of Drugs

Salicylazosulfapyridine — Azulfidine (Pharmacia Laboratories)

Azathioprine — Imuran (Burroughs Wellcome Co.)

(Clinical and Scientific Articles continued on page 677)

Correction

The reproduction of the x-ray film in Fig. 1 of the article "Role of Radiation Therapy in Bronchogenic Carcinoma" by Wagih M. Shehata, M.D., (Vol. 73, No. 9, page 605, September 1977) is inverted. **The Journal** apologizes for this error.

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the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

National Health Insurance

The American Medical Association Council on Legislation has prepared a comparison of major legislative proposals for national health insurance that are pending in the 95th Congress.

More than a dozen national health insurance bills were introduced in the last Congress (94th). Several, some with modification, have already been reintroduced in the current Congress (95th). In principle they seek to make health care generally available to all persons in our society. Each program, in seeking to achieve this objective, creates varying effects upon the economy and the nation's health care system.

Some plans would retain essentially the present system of health care delivery; they would build on the existing structure and make changes to accommodate specific needs. Others would introduce substantial change. One would displace the existing system — provide care through a program totally financed and totally administered by government. Support for a public plan is premised on claimed efficiencies and economies to be derived through health care financing in the public sector and the elimination of private health insurance. This claim is sharply refuted, however, by those who charge that government operation would prove very costly. They point to historical experience of private insurance administration in contrast with that of certain government agencies. They caution that turning over the financing of health care to federal bureaucracy would run the real risk of stifling the health system under piles of paperwork and regulations and creating an institution which is unresponsive to specific needs and lacking in sufficient innovation.

Major bills before the current Congress (95th) are sponsored by AMA (H.R. 1818, S. 218), HIAA (H.R. 5, S. 5), and AFL-CIO (S. 3, H.R. 21). Absent at this time are proposals from AHA, the Chamber of Commerce, and a Long-Ribicoff proposal of catastrophic insurance, but some or all of them may be submitted later in the Congress. The last Administration, as an economy measure, elected not to submit a national health insurance bill, but the current Administration has announced that it is developing legislation for introduction in spring of 1978. The form such legislation might take has not been established.

Types of NHI Proposals

Of the major plans proposed to the Congress over the years, many would continue and expand the concept of health care furnished through employee group insurance. These plans recognize that most persons are presently covered through insurance offered to employees (and their families) and financed entirely by employer and employee, and that need for government financing and additional taxes is accordingly limited. Separate provision is generally made in this type of plan for those who are unemployed, self-employed, or unable to meet the cost of health insurance. Comprehensive coverage — protection against basic and catastrophic expense of illness — would be available to the medically indigent, and the government would share the cost on a scale related to income of the family; it would pay in full the premium for the poor through general revenues and without special taxes. Benefits would be the same for all persons under the separate provisions.

With one exception, the various plans providing employment-based insurance would **require** an employer to offer such insurance to employees and their families. This principle was employed in plans of the AMA (H.R. 6222), AHA (H.R. 1), and the U.S. Chamber (S. 2644), in the last Congress (94th). In this Congress, it is again supported in the AMA plan (H.R. 1818, S. 218), under which employer premium participation would be at least 65 percent of premium but could be at any higher level.

HIAA (H.R. 5), while advocating employment-based insurance, departs from the principle of required employer participation; under this bill, employer participation is **voluntary.** Having elected to make the coverage available even on a voluntary basis, however, the employer must satisfy certain conditions: as examples, he must provide a "qualified" plan meeting broad benefit requirements, and contribute at least 50 percent of the premium. If the program offered by the employer failed to meet these conditions, the employer would lose the benefit of income tax deduction for any premiums he paid for the health care of his employees.

* * * Emphasizing public financing and administration is the Kennedy-Corman plan (S. 3, H.R. 21), which has marked similarities to the British system of a national health service. Rather than private insurance coverage, health care would be provided within a fixed national budget annually established by the federal government. Funds would be created through new social security taxes levied on payroll, wages, and self-employment income for one-half of the cost and through general revenues for the remainder. (For example, of $100 billion of national health insurance costs, $50 billion more would be drawn from general revenues.) These funds would be divided among regions throughout the country and then allocated

(continued on page 668)

Federal Update *(continued)*

to health service areas within each region. All participating physicians and providers would be under contract to the federal government. As a principal form of coverage through capitation, individuals and families would enroll in a prepaid group practice or with a primary physician for a year at a time. Those on the rolls of a primary physician would have all of their care provided (within a stated schedule of benefits) by the primary physician; the services of specialists would be provided only on referral by the primary physician.

* * * Other bills would provide health benefits to limited segments of the population, for example H.R. 1702, The Maternal and Child Health Care Act. Broad benefits for children under age 18 and benefits for women during pregnancy and for illness related to pregnancy for 12 weeks following would be provided. This would be a federal program, financed through social security taxes. A three-man Board appointed by the President would be created in HEW to administer the program, and the Board would name an Executive Director. Claims administration would be provided by the Secretary: he would delegate the authority to the Social Security Administration or he would enter into contracts with carriers to administer the payments. Hospitals would be reimbursed on a prospective bases; "participating physicians" would be paid according to a fee schedule, generally, and capitation for pediatric and maternity care.

THE COMPREHENSIVE HEALTH CARE INSURANCE ACT OF 1977—(AMA Plan)—H.R. 1818 (Reps. Carter, Duncan, and Murphy); S. 218 (Sen. Hansen): full coverage for all through private insurance. . . . . employment-based insurance paid for by the employer and employee . . . . continuing insurance for the temporarily unemployed . . . income related premium subsidy on insurance for the nonemployed and self-employed. . .

Basic Concept: Comprehensive coverage would be provided for all persons through private insurance programs for the employed population, the nonemployed, and others.

THE NATIONAL HEALTH CARE ACT—(Health Insurance Association of America Plan)—H.R. 5 (Rep. Burleson); S. 5 (Sen. McIntyre): comprehensive benefits through voluntary private insurance. . . .income tax incentives for qualified employer insurance plans and individual purchase plans. . . .state plans for the needy.

Concept: Voluntary health insurance for all persons would be provided under three programs. Benefits would be comprehensive and the same under each of the programs.

THE HEALTH SECURITY ACT—(Labor's Committee on National Health Insurance Plan)—S. 3 (Sen. Kennedy); H.R. 21 (Rep. Corman): a plan to restructure the system of health care delivery. . . .totally administered and totally financed (through new social security taxes and general revenues) by the federal government. . . .all health services to be furnished by practitioners, institutions, and others under contracts with the federal government. . . .comprehensive benefits and no copayment. . . .

Concept: All persons would be entitled to comprehensive health benefits. The program would be administered by a five-member Health Security Board appointed by the President and would be financed by new social security taxes and matching funds from general revenues. The Board would divide the country into regions and establish within the regions health services areas with local offices and branches. All providers of health care services — professional practitioners (physicians, dentists, optometrists, or podiatrists), institutions, laboratories, among others — wishing to participate in the program would have to enter into contracts with the federal government and agree to specified conditions. All health services would be provided within a fixed budget.

THE MATERNAL AND CHILD HEALTH CARE ACT—(A New System for Maternal and Child Health Care Benefits)—H.R. 1702 (Rep. Scheuer): Broad health care benefits for children. . . .maternity and maternity-related health care benefits for women. . . .federal fee schedules and annual capitation for pediatric services or maternity care. . . .prospective rate-making for institutions. . . .

Concept: A federal system would be established to provide health care for a segment of the population. It would offer comprehensive benefits for children (under age 18) and maternity benefits for women during pregnancy and for 12 weeks immediately following the pregnancy.

A copy of the 12-page analysis prepared by the AMA Council on Legislation may be obtained by writing: Department of Federal Legislation and Public Policy, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, telephone 614/228-6971.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Laetrile Bill Stalled In Senate Committee

The controversial Laetrile bill, HB 650 (Sweeney, D-Cleveland), has been brewing in the Ohio General Assembly for more than four months. The Ohio Senate Education and Health Committee has been reviewing the legislation with both proponents and opponents having an opportunity to present testimony before the Committee.

Proponent testimony was presented on September 20 by physicians treating patients with Laetrile and by individuals who believe themselves to have been successfully treated with Laetrile. The thrust of the proponent testimony was similar to the promotion over the past 30 years of other unproven cancer cures, such as Krebiozen, Hoxey's treatment, and Koch's remedy. As with the other alleged cures, the supporters of Laetrile always substitute attacks on the medical and scientific establishment for controlled scientific evidence. They indicate that orthodox medicine is not qualified to pass judgment on Laetrile and in addition, supporters promote the freedom-of-choice issue.

On September 27, the OSMA and other opponents of HB 650 testified before the Committee. In addition to OSMA Staff testimony, physician testimony was provided by Herman Freckman, M.D., Cincinnati; Arthur James, M.D., Columbus; Richard Meyer, M.D., Cincinnati; Thomas Stevenson, M.D., Columbus; and Robert Young, M.D., Johnstown. Opposition testimony was also presented by Dr. David Yohn of The Ohio State University Comprehensive Cancer Center and Robert S. Young, M.D., an official of the United States Food and Drug Administration (FDA). Patient testimony came from two individuals successfully treated by conventional methods.

The testimony of the OSMA's opposition witnesses focused on three areas: (1) the unproven efficacy of Laetrile (as shown in controlled scientific tests); (2) the questionable safety of Laetrile; and (3) the public-policy question of legislative action providing a drug without evidence of effectiveness and safety. Due to the expert testimony, the OSMA was successful in keeping the bill in Committee for at least another month.

HB 650 brings to the Legislature a well-organized and orchestrated performance by the backers of Laetrile. Some witnesses said Laetrile had saved their lives; others argued that although Laetrile had not been shown effective scientifically, they should have the right to take any drug they believe helps.

These statements are in direct conflict with current laws on drug development and therapy. The U.S. Congress enacted requirements for new drugs marketed in the U.S., requiring substantial evidence of both effectiveness and safety. The evidence can only be developed through controlled chemical experimentation and substantial support in scientific literature. As stated previously, the backers of Laetrile have yet to provide the Legislature or the FDA with evidence that meets these requirements.

Physicians have to confront increasing hostility in their cancer patients. Americans are not only frightened by the disease, but also by cancer therapies, no matter how successful. Laetrile is presented as both a "painless" alternative to traditional therapy and as a way to make traditional therapy more effective. Patients fear surgery, radiation, and chemotherapy. The Laetrile supporters use this fear by claiming their product does not cut, burn, or make a patient ill.

Hopefully, the testimony of concerned physicians will have some impact on the legislators. The Laetrile campaign has lost steam in other states. California recently killed their bill in committee. The governors of New York and Illinois vetoed bills presented to them. While 12 states have authorized the use of Laetrile, eight have rejected Laetrile legislation this year. Perhaps more important, the first malpractice suit was filed last month against John Richardson, M.D., of Albany, California. Through his attorney, the physician, who lost his license last year for treating patients with Laetrile, claims that he was treating the patient's body nutritionally to resist all diseases.

The toxicity of Laetrile is now under investigation, and this aspect alone may be reason enough not to permit the use of the drug. In a report released on July 12, 1977, Joseph F. Ross, M.D., cites 37 cases of acute cyanide poisoning and the potential of chronic poisoning leading to neurological degenerative diseases if the drug is taken over a period of time. Substantiation of the toxicity problem will require further review. Until that review is completed, the Legislature should not permit a potentially toxic drug to be used simply because some people believe it works.

Until the Ohio Legislature resolves the question of Laetrile's legality, physicians should not use this drug. The medical licensure laws require a physician to "employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease" (4731.22 ORC). A physician can lose his license for prescribing or administering drugs for other than legitimate therapeutic purposes; conviction of any federal law regulating the possession, distribution, or use of any drug; or by representing that an incurable disease or condition can be permanently cured (4731.22 ORC).

The Senate Committee will likely take up the Laetrile issue when the session resumes in mid-October. OSMA members should contact their local senators and the members of the Senate Education and Health Committee (See *The Journal,* Vol. 73, No. 6, June 1977, page 357.) to emphasize the importance of delaying this legislation until conclusive scientific evidence of efficacy and safety is developed.

(continued on page 670)

State Update *(continued)*

Ohio Optometrists Continue Pressure to Move Optometric Bill

Although the Ohio Optometric Association has placed intense pressure on members of the Senate Rules Committee to move SB 163 (Jackson, D-Cleveland), the bill remains in the Committee. This bill would permit optometrists to administer "diagnostic pharmaceutical agents."

Optometrists from all over the state have been contacting senators daily in an attempt to move the bill out of the Rules Committee to the Senate floor for a vote. The Rules Committee plays an important role in the success or failure of this legislation. If the Rules Committee holds on to SB 163 indefinitely, the bill will die.

The only way SB 163 can be kept from the floor is to counter the optometrists' pressure with legislative contacts by physicians of all specialties. You should contact members of the Senate Rules Committee (See *The Journal,* Vol. 73, No. 8, August 1977, page 515.) and your local senators to express your concern about the hazard of non-medical practitioners administering dangerous drugs.

Certificate of Need Legislation Introduced in Both Houses

Certificate of need legislation has been introduced in both the Ohio House and Senate. Sen. Marigene Valiquette (D-Toledo) has sponsored SB 349, and Rep. Dennis Eckart (D-Euclid) is the sponsor of HB 864. These are identical bills. The Finance Committees of both the House and Senate have begun hearings on their respective bills, placing them in subcommittee for further study. OSMA testimony has been presented in both the House and Senate by the OSMA Department of State Legislation and the OSMA Councilor C. Douglass Ford, M.D., Toledo.

This legislation has its origin in a federal requirement mandated in PL 93-641, the National Health Planning Resources and Development Act. Some form of certificate of need program is required by July 1, 1978 for the State of Ohio to qualify for federal financial aid to state health services projects.

In 1975, the Ohio Legislature passed a certificate of need law (HB 908) which authorized the Ohio Department of Health to issue regulations implementing a capital expenditure review program. The Department of Health is currently working on the development of these regulations, and it is expected that a public hearing of the Public Health Council Regulations will be scheduled for late November.

Some members of the General Assembly believe the Department of Health has delayed implementation and feel the Public Health Council Regulations will not go far enough to accomplish the desired goals of a certificate of need program. In large part, delay in adoption of the regulations can be attributed to the slowness with which HEW developed its own federal regulations for certificate of need. It was not until January 21, 1977 that HEW adopted partial regulations. These were amended in April, and the final regulations are still being drafted.

The two proposals under consideration by the General Assembly include a combination of federal laws and regulations, suggestions of Ohio's areawide health planners (HSAs), and portions of a model certificate of need law developed by Ralph Nader's Health Research Group.

The passage of the certificate of need bills would have far-reaching implications for physicians and hospitals as far as capital expenditures are concerned. The requirements of these bills exceed those spelled out in federal regulations, making them unnecessarily restrictive. These requirements could have an adverse effect on the maintenance of existing facilities and services through the application of "appropriateness" reviews. SB 349 and HB 864 would:

1. Bring under review all existing services and facilities;
2. Give the State the power to terminate or alter existing services or facilities found to be "inappropriate";
3. Continue the 1122 Review Program (a duplication of certificate of need);
4. Require a "reasonable" filing fee for applicants;
5. Further dilute provider representation on the Statewide Health Coordinating Council (SHCC);
6. Establish an Appeals Board consisting of the Director of the Office of Budget and Management, the Director of Insurance, and the Auditor of the State (replacing the Public Health council in hearing appeals);
7. Provide sanctions, including criminal (with penalties of up to $1,000 per day), injunctive relief, and denial of third-party reimbursement if either the HSA or the State disapproves the project.

The Department of State Legislation will be working closely with the subcommittees in both houses to rectify the portions of these bills that are objectionable to the OSMA.

OSMA Members

Physicians interested in issues pending before the Ohio General Assembly and/or interested in providing testimony on these issues, contact the OSMA Department of State Legislation, 600 S. High Street, Columbus, Ohio 43215. Telephone: 614/228-6971.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

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Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

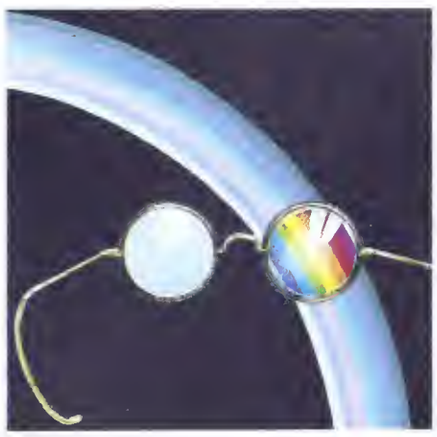
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

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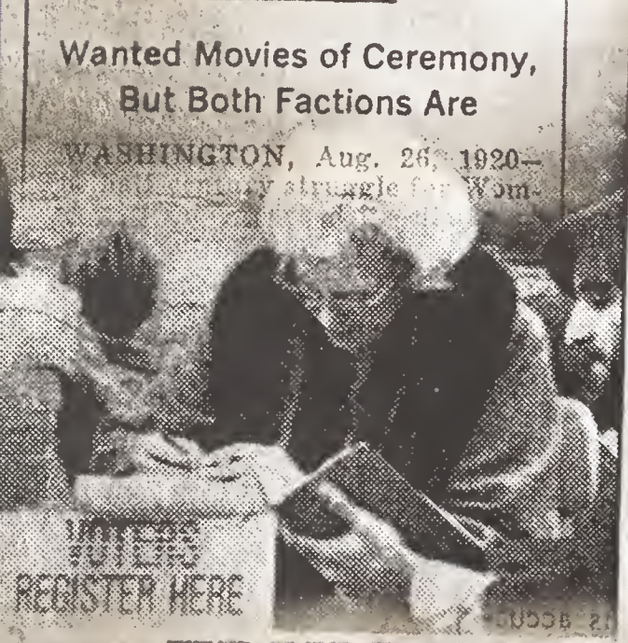
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WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age per and counted upon to benefit 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the me "the cornerstone in a stru which is being built but is me[illegible] complete

COM

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

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NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary

IGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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THE OHIO STATE Medical Association Clinical and Scientific Specialty Series

Recognition and Management of Breast Cancer

Thomas D. Stevenson, M.D., Moderator
Frank Batley, M.D.
William S. Blakemore, M.D.
William J. Holaday, M.D.
Myron Moskowitz, M.D.

Editor's Note: *In late 1976, the OSMA Committee on Cancer agreed to provide material on the subject of carcinoma for the Clinical and Scientific Specialty Series of* The Journal. *The Committee chose the subject "carcinoma of the breast" and elected to accumulate the data for the manuscript by means of a roundtable discussion by participants selected for their knowledge of this disease entity. This discussion was held February 13, 1977 at the Association's Headquarters.*

As the manuscript developed, it became evident that this material was of the quality that would lend itself to a category I continuing medical education test that could accompany the manuscript when published. With the sponsorship and guidance of the OSMA Committee on Scientific Work, such a test was developed. It appears on page 691 of this issue and qualifies for two (2) hours of category I credit.

We would like to express our appreciation for the cooperation of the OSMA Committees on Cancer and on Scientific Work and the OSMA Departments of Health Education and of Continuing Medical Education. This cooperation has led to the following article and the accompanying category I continuing education examination, the first to be published in The Journal *as a benefit to our member physicians. OSMA-member reaction to this format would be appreciated.*— **R.L.M. & L.A.J.**

CARCINOMA OF THE BREAST **is the leading cancer encountered in women. It has been estimated there are approximately 90,000 new cases of breast cancer in the United States per year, and 35,000 deaths due to this disease entity. Impressive advances have been made in the recognition and management of carcinoma of the breast, and it is the purpose of this panel to summarize for the primary care physician the current approach to this disease. The panel will consider three clinical problems, and will discuss the following:**

1. **The proper approach to the patient with a mass in the breast;**
2. **The contribution of radiologic techniques, particularly mammography, to the diagnosis of breast cancer;**
3. **The role of radiation therapy in prophylaxis and definitive treatment in carcinoma of the breast;**
4. **The role of the pathologist and the importance of histopathologic classification of breast cancer; and**
5. **The role of chemotherapy both in advanced disease and as adjunctive therapy.**

MODERATOR STEVENSON: The first patient is a 32-year-old, nulliparous woman who consulted her physician because of a lump in the outer-upper-quadrant of her left breast. The mass had been present for a month and had shown some slight variation in size. Her health has been excellent in the past. Her mother died of carcinoma of the breast at the age of 52 years and her 42-year-old, older sister had had a radical mastectomy for breast cancer.

On physical examination, the mass was approximately 2.5 cm in diameter, firm, movable, and nontender. No nodes were palpable in the axilla.

Dr. Blakemore, would you comment on the physical examination of the breast in this patient, particularly in regard to the findings indicative of breast cancer, and helpful in differentiating a neoplastic from a benign lesion?

Diagnosis: Clues From the Physical Examination

DR. BLAKEMORE: This history is very important. We should know the relationship of the lesion to her menstrual cycle, whether she's been pregnant; late pregnancy is one of the hallmarks of high risk in breast cancer. It is also important to know if there has been any trauma to the

breast or discharge from the nipple.

The size of the lesion and the fact that it is movable are factors which indicate it may be benign. Also, the fact that she is young. She has not noted any pain, and there is no heavy, scaly, skin pigmentation characteristic of fibroadenoma. The positive family history puts her in the high risk category. The location of this lesion in the outer-upper-quadrant of the breast indicates that it should be considered malignant until proved otherwise.

MODERATOR: Is dimpling of the skin the most important *single* physical finding indicative of a malignant breast lesion?

BLAKEMORE: Skin retraction is one of the important factors, but with the availability of mammography, it has less significance. Benign lesions with fat necrosis may have attachment to the skin, and cause some confusion.

MODERATOR: Dr. Moskowitz, would you comment?

DR. MOSKOWITZ: I will comment on the physical findings at this point, particularly the classical findings that have been discussed — skin retraction, fixation of the mass, nipple inversion, pectoral muscle fixation, invasion of Cooper's ligaments, and peau d'orange. These are classical signs of advanced, *invasive, incurable* carcinoma of the breast. If we wait for these signs, there is no question that we can diagnose carcinoma reliably at a stage when we can do very little about it.

As far as I am concerned the presence of a lump in the breast on physical examination with either benign or malignant characteristics is cancer until proved otherwise if it persists through a menstrual period. We have had the unpleasant experience of seeing some very early changes on mammogram unaccompanied by any physical findings; we didn't have the courage to suggest biopsy or a biopsy was not done for one reason or another; and we continued to follow these patients. As these lesions changed, and became obviously a small carcinoma radiographically, the clinical findings were those of a small, soft, movable mass — classical of a lipoma.

Based on our experience, our approach in Cincinnati is rather aggressive and we biopsy on the basis of physical examination. We feel that the presence of a lump that persists through a menstrual period in a woman of 35 years or over requires an excisional biopsy, or needle aspiration if it feels cystic. I feel that mammography offers very little diagnostic assistance in the presence of a palpable lump. The role of mammography in the presence of a palpable lump is to inform us if there is a lump in the contralateral breast.

MODERATOR: Any lump that persists through one menstrual cycle in a woman over age 35 years is an indication for excisional biopsy, and mammography should be done; but the decision as to whether or not to biopsy should not depend on the mammogram?

MOSKOWITZ: Absolutely, if the mammogram detected another area that can't be felt, it should be biopsied also.

MODERATOR: Dr. Blakemore, would you agree?



Thomas D. Stevenson, M.D.

BLAKEMORE: With one exception. In those patients you think have cystic disease, it is acceptable, though controversial, to do an aspiration of the cyst. These patients must be followed carefully to make sure there is no recurrence. It is advisable to do a cytologic study on the aspirate.

DR. BATLEY: I have a comment on physical examination. I believe it is important to examine the patient sitting up, and get the pectoral major muscle relaxed so you can get into the axilla and feel for lymph nodes. It is very difficult to examine a patient for carcinoma of the breast when she is lying in bed because the supraclavicular nodes are very important and you have to practically climb into the bed to adequately examine the supraclavicular fossa.* We occasionally see patients after radical mastectomy with a palpable supraclavicular node which has been missed, and, of course, radical mastectomy has been unnecessary in that situation.

MODERATOR: Adequate examination of the breast requires an examination with the patient recumbent and sitting up, a careful examination — not just a casual palpation for lumps. Is this correct?

BATLEY: Certainly not a casual palpation at any time.

MOSKOWITZ: I would suggest that physicians making physical examinations of the breast learn to use their left hand to examine the patient's right breast. There is an even distribution of involvement of the left and right breast among patients in our screening center because they all have mammography as well as a physical examination. Yet, the preponderance of cancers found on physical examination alone are in the left breast, which is a manifestation of the fact that our examiners are predominantly right-handed. If we start using our left hands a little more, we will find 4 percent simultaneous, bilateral breast involvement. I think more can be found by physical examination in the right breast by using the left hand.

MODERATOR: Dr. Blakemore has indicated that if a cyst is suspected, needle aspiration with cytologic examination may make an excisional biopsy unnecessary. Dr. Holaday, what's been your experience?

DR. HOLADAY: Most cancers are not cystic. Occasionally, if there is

*This method of examination is rather unique to Dr. Batley and is not generally recommended. (Moderator)

some cytodegeneration, blood may be aspirated. The cyst which is fibrocystic disease in which there is pressure atrophy of the epithelium and fluid accumulation, goes away following aspiration.

On the other hand, if there is lesion such as an intraductal papilloma with cellular atypism, you are confronted with a dilemma. In my experience, most breast cyst aspirates are overread and result in a series of qualifications of the word atypia that aren't very helpful.

Dialogue between the pathologist, and the physician who aspirated the breast lesion, is needed. The persistence of any mass following the aspiration of the cyst, regardless of what the pathologist says on the basis of the cytology, shouldn't interfere with the management. Just ignore the dilemma, and go on to the biopsy. As a practitioner of cytology. I really don't have too much faith in breast aspirations. I don't think you should throw the fluid away, either.

BLAKEMORE: I agree. If there is any question, a biopsy should be done.

MODERATOR: The panel seems to agree there is no place for so-called watchful waiting in a woman who has a persistent mass in the breast.

BLAKEMORE: Watchful waiting is a very dangerous concept.

Staging and Treatment

MODERATOR: Let's proceed with the further evaluation of this young woman with a lump in the breast. Excisional biopsy was positive for carcinoma of the breast, mastectomy was performed with axillary dissection, and 6 of 12 axillary nodes were positive for metastases. This is stage II carcinoma of the breast.

Dr. Batley, would you comment on radiation therapy for this patient? Is there a role for radiation therapy in the management of this patient?

BATLEY: For many years I have not given postoperative radiation for carcinoma of the breast even when the patient had positive axillary nodes. This is rather controversial statement and I would like to explain why. Radiotherapy works best when you can treat a small volume. When you treat a small volume, you can treat to a high dose. Indeed, as I hope will come out later with some of the other patients, we can control local disease in the breast and on the chest wall with radiotherapy.

If you treat the internal mammary or axillary node with radiotherapy, you are treating a large volume. If the internal mammary nodes and all the high axillary nodes are involved, the patient probably has distant metastases and, therefore, your aim of treatment should be directed to control of occult metastases or at least not to accelerate their growth. There is some evidence, although this has been disputed, that radiation particularly of the anterior mediastinum can interfere with the patient's immune resistance and, therefore, perhaps accelerate the rate of growth of occult metastases. Later, I want to point out how I would use radiotherapy for local carcinoma of the breast, because I think radiotherapy often is used in the wrong situations. In this particular instance, where the patient has had a mastecomy, I would not give postoperative radiation.

BLAKEMORE: I agree with Dr. Batley. It would be only fair to point out that this is an area that is not absolutely agreed upon. It is being evaluated in clinical trials.

It is very important to determine the proper disease stage of these patients. Every physician should make an effort to stage the patient before surgery so that he can plan therapy. The selection of treatment, surgery, x-ray therapy, hormonal manipulation, chemotherapy or immune therapy, is determined by the stage of disease.

MODERATOR: Dr. Moskowitz, would you outline an adequate diagnostic evaluation of this patient?

MOSKOWITZ: Let me speak for a moment about the role of diagnostic radiology in evaluation of the axilla. It is of no value in determining the presence or absence of axillary lymph node involvement. The next problem concerns what can be accomplished by radiologic studies to determine the presence or absence of metastases. At a minimum, it is certainly worth an x-ray film of the chest. I believe that a reasonable approach in an institution without nuclear medicine facilities is a routine bone survey which would include skull, spine, pelvis, and both femurs. There is no point in x-raying distal to the femur because metastases distal to the knee are relatively infrequent.

There is no question that the bone scan is positive before bone lesion can be detected by x-ray examination since you have to have 50 percent bone loss or demineralization to see a metastasis on a standard x-ray film. However, not every positive bone scan will be the consequence of metastases since there are other conditions including degenerative arthritis which may produce a positive scan. If the patient with invasive carcinoma of the breast has a negative bone survey, no joint or inflammatory disease, and a positive bone scan, you can assume a metastatic process is present, and will be correct more than 90 percent of the time.

MODERATOR: I agree that patients most often do not have metastatic lesions detected at the time of their initial evaluation, but we routinely do a bone scan, brain scan, and electroencephalogram (EEG), the latter because a brain scan will not detect lesions in the posterior fossa; bone marrow biopsy, liver/spleen scan and a biochemical profile. Usually these studies are negative, but are justified on the basis of establishing a baseline.

BATLEY: One can go overboard in conducting investigations such as metastatic surveys and other studies. I have read recently that the brain scan is noncontributory unless the patient has neurologic signs.[1]

MODERATOR: That's right.

MOSKOWITZ: I think Dr. Batley is correct. When you stop to think about the sensitivity of a hepatic scan, which can only detect masses in excess of 2 cm in diameter, we could reduce the number of diagnostic studies. It would

be ideal to get the cost of (CAT)* scanning down to where it becomes feasible. I still think there's nothing wrong in evaluating the patient at a community hospital where nuclear medicine studies may not be available. I feel an x-ray film of the chest and a bone survey is a reasonable diagnostic work-up for gross evidence of disease. I would not deny a patient primary treatment if the results of both were negative.

MODERATOR: Dr. Blakemore, would you comment on that?

BLAKEMORE: Yes, particular attention ought to be paid to any evidence of points of pain in the skeleton since pain often precedes the appearance of radiologic findings by a significant period of time. I believe all breast specimens should be examined for estrogen and progesterone binding; hormonal studies should be made on *all* breast lesions.

MODERATOR: It is the concensus of the panel that the minimal staging procedure should be for the detection of bone metastasis. We assume that the evaluation of the patient would include a chest roentgenogram and certain biochemical determinations.

When a breast mass is removed, important information is gained by determining whether or not there are binding sites in the tumor for estrogen. This is important in determining the response to either endocrine ablation or to endocrine additive therapy. Dr. Holaday, would you comment on the processing of the tissue for hormonal binding?

HOLADAY: The pathologist contributes to the management of patients with breast cancer in many ways, and certainly determination of estrogen binding is important. In our laboratory, it is a *routine* procedure on every breast biopsy considered malignant on frozen section.

I'd like to comment, if I may, on the concept of staging which is really a definition of the extent of disease. In case of breast carcinoma, there is one single, hard, bit of data that is definitely related to prognosis, and that is the status of the axillary lymph nodes. All the other methods of evaluating the stage of the disease such as CAT scanning, bone, liver scans, and others are really predicated on the basis of the very poor clinical evaluation of the so-called "negative axilla." If the patient has axillary nodes that are positive clinically, you can anticipate 90 percent or greater accuracy in predicting microscopic metastases in the axillary nodes. In the patient without enlarged nodes clinically, we find the *clinically* negative nodes have a significant number of microscopic metastases on pathologic examination. There are other matters related to the extent of the disease and prognosis, such as the histologic type of breast carcinoma. As a matter of convenience, it is tempting to combine all breast carcinomas into one group, since about 75 to 80 percent are the same histologic type. There are other types, and although they constitute less than 20 percent, they are important because they are associated with an excellent prognosis. Lobular carcinoma in situ, and intraductal carcinoma rarely have involved nodes because they are in situ lesions. In contrast to invasive ductal carcinoma, invasive lobular carcinoma is almost always associated with axillary node involvement, depending upon the location of the primary tumor and its size. To comment on this case, I was surprised to find a description of six positive axillary nodes when the primary was 2 to 2½ cm in diameter. In a neoplasm that size, I wouldn't expect to find any positive nodes, just on the basis of a small primary carcinoma. But they are present, and the prognosis for the patient is very poor. In our experience at The Ohio State University, 50 percent of the mastectomy specimens have negative nodes, and about 25 percent of our patients have four or more nodes positive for metastases. The prognosis for this particular patient would be poor because of the number of nodes involved.

Another point is that there is description of only 12 nodes found in the specimen, which I would interpret as indicating that the patient had less than a classical Halsted radical mastectomy. In the true radical mastectomy, which includes the low pectoralis muscles, breast and axillary lymph nodes removed in a block, I would expect to find at least 20 to 25 nodes in the specimen.

Adjunctive Chemotherapy

MODERATOR: To summarize, then, this woman with proved carcinoma of the breast and axillary lymph node involvement would not be a candidate for radiation therapy as part of her postoperative treatment. The work-up would be adequate on the basis of what has been described although there are differences of opinion as to the extent of the diagnostic studies that might be made. Assuming there is no evidence of disease beyond the involved axillary nodes, and the impressive evidence that a patient with four or more positive nodes has a high risk for recurrence, this patient would be a candidate for adjunctive chemotherapy. Dr. Blakemore, do you agree?

BLAKEMORE: Yes, the fact that she is premenopausal and has significant axillary lymph node involvement would put her at high risk for recurrence and would justify the administration of chemotherapy. The preliminary data are very convincing so that it seems almost mandatory that some type of chemotherapy be administered, and the current data indicate that multiple agents are more effective than single agents. One combination is referred to as CMF, which is cyclophosphamide methotrexate, and 5-fluorouracil; another is VA (a combination of vincristine and adriamycin); and the single agent, L-Pam Alkeran®) L-phenylalanine mustard which has been used by various groups for several years. These studies clearly indicate that the recurrence rate in the premenopausal woman can be significantly affected by adjunctive chemotherapy. However, the total duration of observation is less than five years, and data concerning the efficacy of extensive chemotherapy in breast cancer are still being accrued. Adjunctive chemotherapy is not without complications; it should not be used casually by those inexperienced

*CAT — computerized axial tomography.

in cancer chemotherapy. The patient who receives adjunctive chemotherapy should be included in a protocol study, and be fully apprised of the fact that the therapy is experimental at the present time. Current studies indicate that chemotherapy should be continued at least 12 months and perhaps longer.[2]

Two other questions arise as to whether oophorectomy should be performed and a biopsy of the contralateral breast made.

BATLEY: Dr. Blakemore suggested castration in this patient. If the patient had estrogen binding sites in the primary tumor, castration should be seriously considered. Radiation castration is a simple procedure and regarded by many as effective as oophorectomy. The usual procedure is the administration of 1,500 rads in approximately five days.

HOLADAY: The data concerning the use of adjunctive chemotherapy seem reasonably clear, but the data concerning castration in a prophylactic situation are not as clear. As you know, previous studies indicate that prophylactic oophorectomy delays, but does not prevent, recurrence.[3] There is, however, a current study to determine whether patients with estrogen binding sites in the tumor will fare better following oophorectomy than those who do not have oophorectomy.

BATLEY: The Manchester study demonstrated that postoperative radiation given to axillary and supraclavicular nodes did not improve survival rates, but radiation castration to pre- or perimenopausal women extends the recurrence-free time and five-year survival rate.[4] However, the survival curves were similar at ten years.

There are those who have interpreted these data to indicate that if you have distant metastases, there is no reasonable hope of cure, and, therefore, no point in having to prolong survival rate. I hope I am making my point clear. If you have an excellent chance of survival to five years without recurrence without aggressive therapeutic measures, why not accept that modicum of useful life even though the possibility of living to ten years is remote? We are going to die some time.

Follow-up Procedures

BLAKEMORE: I think it important to point out the follow-up measures that would be necessary for this patient. Even though she is a young woman, mammography should be done at regular intervals, since she is at high risk for recurrence of breast cancer. Chest x-ray examination, in addition to repeated physical examination, should be made at regular intervals, certainly no less than once a year. It is very important to alert the patient to the necessity for a careful follow-up, so that she does not miss appointments or fail to seek medical advice if she should move to another area.

MODERATOR: The patient with breast cancer is at high risk for the development of a second carcinoma of the breast. What would you consider a practical time interval for following-up the patient's case after her release from the hospital?

BLAKEMORE: The patient should be seen monthly for the first three months, and then at three-month intervals for the first year. This patient should be seen four times a year for at least two years and every six months after that because a large number of her lymph nodes are involved.

HOLADAY: Theoretically, Dr. Blakemore, that's correct, but pragmatically the case is moot because in order to develop a second primary, you have to outlive the first breast cancer, and I think her chances of doing that are poor. I would categorize her follow-up examination as similar to biopsy of the contralateral breast at the time the original surgery is done. I would be pessimistic that anything that is done will have any favorable influence on the outcome.

BLAKEMORE: Dr. Holaday, the follow-up is not just for recurrence of this disease in the other breast but for recurrence at any other site. Second, a mirror-image biopsy has to be done almost philosophically because we would not know the status of the contralateral breast at the time of surgery. Obviously, if we knew she had axillary lymph-node involvement or remote metastases, our enthusiasm for mirror-image biopsy of the contralateral breast at the time of original surgical procedure would be diminished.

MODERATOR: Dr. Moskowitz, would you comment about the type of radiologic techniques you would use in follow-up?

MOSKOWITZ: A comment concerning the mirror-image biopsy of the contralateral breast: we may be mixing apples with oranges in this particular situation. For example, this patient with positive axillary lymph nodes may not be reasonably suspect even if she has a significant lesion in the contralateral breast. On the other hand, in the situation where the patient has a biopsy for a minimal breast lesion not suspected to be carcinoma, a negative physical examination, an equivocal mammogram, and then a mirror-image biopsy is done, we may find an invasive carcinoma in one breast and an in situ lesion in the other breast. I have just seen this exact situation in a 42-year-old woman, ie, as in situ lesion in one breast and invasive carcinoma in the other. The surgeon who submitted the specimens on this patient does bilateral biopsies routinely and to be perfectly honest, the lesion in the breast that was suspect was an in situ carcinoma. In the contralateral breast, there was a 1½-cm invasive carcinoma. The axillary nodes were negative. Nobody suspected the presence of carcinoma in the contralateral breast. We are encountering this type of situation more frequently and the judicious use of contralateral breast biopsy combined with mammography may provide us with a firmer basis upon which to recommend a biopsy of the contralateral breast.

Returning to the initial question about radiologic follow-up in this patient, I would recomend that a mammogram be made on an annual basis because of the high risk of recurrence.

Role of Mammography

MODERATOR: Dr. Moskowitz, would you indicate the patients who should have an annual, or perhaps a biannual, mammogram?

MOSKOWITZ: Everything else aside, the greatest risk factor is age, increasing age. The incidence of breast cancer increases significantly between the ages of 35 and 37½ years. In the group between the ages of 35 and 40 years with any risk factor, such as palpable breast lump, a family history of breast cancer, discharge from or painful breasts, the incidence of carcinoma is great enough to justify screening on an annual basis. Below the age of 35 years, mammographic screening should be limited to those individuals who have a suspicious lump in the breast and who, in the judgment of their physicians, are at high risk for the development of breast cancer.

For example, since this patient's mother and sister had breast cancer, she is 47 times more likely to have a carcinoma before the age of 35 years than an individual age-matched in the general population. It is more likely to be bilateral and very likely to be hormonally dependent. The latest data to be presented by the Upton Committee of the National Cancer Institute for evaluating radiation risk of mammography will indicate there is no increase in risk for inducement of breast cancer if you already have a significant risk factor. The possibility of breast cancer far exceeds the risk of radiation-induced carcinoma in high-risk patients.

Other known factors which increase the possibility of developing breast cancer, parity, lactation, and other, are minimal factors as far as I'm concerned, and I don't think we know enough about the effect of diet and obesity to talk confidently about their contribution. There should be some mention, however, about the type of mammographic procedure that is performed. I feel if you are going to have mammography it should be low-dose radiation mammography, not just a mammogram. By definition, low-dose mammography implies the administration of 1 rad per year or less, and that should be a measurable quantity of radiation. If the mammographer cannot measure and determine the amount of radiation to be delivered in the course of a mammographic examination, the procedure should not be done.

MODERATOR: Dr. Moskowitz, it would appear that if the individual is at high risk for the development of breast cancer, one should assume the minimal, perhaps negligible, risk factor associated with an annual mammogram.

MOSKOWITZ: Yes, in the high-risk patient, the benefits will exceed the risks.

BLAKEMORE: When would you x-ray the chest in the follow-up period? How often in this type of patient?

MOSKOWITZ: I've seen chest x-ray films change from normal to abnormal in a very short period of time. However, I generally recommend that in the follow-up of a patient with breast cancer a chest roentgenogram be made twice during the first year and annually after that. I think we can produce a great deal of anxiety in the patient by being overzealous in our follow-up examinations.

BLAKEMORE: Do you consider thermography valuable for diagnostic screening?

MOSKOWITZ: No, I don't believe thermography is of value for screening; it may be some help in prognosis. It is of no value in screening because there are too many other changes in the breast that produce false positive results. An early carcinoma of the breast doesn't give a true positive with sufficient frequency. On the other hand, there is evidence to suggest that a patient with a palpable breast mass or a tumor demonstrable by mammography with a very positive thermogram has a poorer prognosis than those individuals with a similar type of disease, but with a negative thermogram. This correlation with prognosis is based upon work done in France, and if it can be confirmed, it will clarify the value of thermography in the evaluation of the patient with breast cancer.

MODERATOR: You feel that thermography has no value as a diagnostic procedure in breast cancer?

MOSKOWITZ: That's correct. In my judgment, it is of no value in diagnosis.

MODERATOR: Are there any further comments concerning this patient with stage II carcinoma of the breast?

BLAKEMORE: I think that she should be considered to have the disease for the rest of her life. A five-year follow-up is not adequate; ten-year follow-up is certainly a routine procedure. I think her case should be followed-up indefinitely.

MODERATOR: I certainly agree, Dr. Blakemore, because breast cancer may have late recurrence, in contrast to most other tumors which recur within a period of five years after detection of the primary. As you know, it is possible to have a recurrence of breast cancer as long as 20 years after the initial breast cancer is detected.

The next patient, a 60-year-old woman, has a large tumor, 4 cm in diameter, in the medial-lower-quadrant of her right breast, and a palpable node in the right axilla. Results of the remainder of the physical examination are normal. Clinically, she has stage II disease and, on the basis of a physical examination, an obvious carcinoma of the breast. What about the diagnostic approach to this patient? Specifically, before any therapeutic measures such as surgery are done, should she have a full staging evaluation as we have just discussed? Dr. Blakemore, would you insist that a bone scan be done before you would proceed with surgery?

Management of Breast Cancer in the Postmenopausal Patient

BLAKEMORE: No. I would go ahead and do the operative procedure on her while she was in the hospital. I would not delay the surgery unduly

in order to have a full staging procedure.

MODERATOR: I assume that your routine procedure is excisional biopsy and frozen-section diagnosis, with preparation of the patient prior to operation for radical mastectomy. If the frozen-section diagnosis was carcinoma of the breast, would you proceed with a radical mastectomy?

BLAKEMORE: Hopefully, I would have a roentgenogram of the chest made and a scan done the day of admission on a patient like this. With that information, I would try to proceed with radical mastectomy.

MODERATOR: Would you want the bone scan done prior to the surgical procedure?

BLAKEMORE: Yes.

Radiation Therapy

BATLEY: This is a very large tumor, and I think staging is very important because the tumor is probably fixed to muscle. To adequately examine the patient with carcinoma of the breast, we should advise the physician to put the pectoralis major muscle on the stretch by having the patient put her hands on her hips and then pushing in on her hands, and in this way put tension on these muscles. If you see the tumor move when the maneuver is performed, it implies that the tumor is fixed to muscle and then it is a stage III carcinoma. Stage III carcinomas do not respond well to surgery because there is the implied risk of spread during the surgical procedure. It has been suggested by Hagenson that these patients should not be operated on without prior therapy. In this patient, I would prefer preoperative radiation. As a matter of fact, one radiologic aphorism is that the patient referred for postoperative radiation is the patient who should have been considered for preoperative radiation. In practice, it is very difficult to administer preoperative radiation after the surgery has been performed. Therefore, when this type of patient is referred to me from a family physician or one of the less aggressive surgeons, the patient has advanced disease, and does very well with local radiotherapy. In France, they have been using radiation for the primary treatment of carcinoma of the breast for many years with a good local control and satisfactory survival rates. Recently, Dr. Samuel Hellman of Peter Bent Brigham Hospital in Boston, has demonstrated that local radiation therapy for carcinoma of the breast is as successful as surgery because it is not the local disease that kills the patients, but the metastatic deposits.[5] If you treat this patient with local radiation therapy, I would expect to be able to control the local disease in such a complete manner that subsequent surgery would be unnecessary. We refer these patients back to the surgeon after the radiation therapy only if the disease has not disappeared completely or begins to recur.

MODERATOR: The point of your argument, Dr. Batley, if I interpret you correctly, is that this patient should have full staging procedures done prior to a therapeutic decision such as a radical mastectomy.

BATLEY: Yes, including an evaluation by the radiation oncologist.

BLAKEMORE: I think that would



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depend somewhat on the nature of the tumor. A 4-cm mass that is not attached to the muscle is not necessarily the same as one that is attached.

HOLADAY: You are assuming that this is a cancer, and I bet you it isn't. Are you going to do a biopsy before you determine whether it is or not?

BATLEY: Obviously, the patient should have a biopsy with sufficient tissue for all of the necessary laboratory studies, including estrogen receptors. However, prior to talking about a simple or radical mastectomy, the patient should be considered for preoperative radiation. Any physician who sees a large number of patients with carcinoma of the breast can pretty much predict what the biopsy is going to indicate. There is no reason why this patient shouldn't be seen by the radiation therapist prior to the biopsy. I certainly wouldn't give preoperative radiation or radiation without a pathologic diagnosis.

MOSKOWITZ: Would you consider needle biopsy?

HOLADAY: *I* would. A needle biopsy is fairly easy to read.

BATLEY: At one time, I would treat on the basis of a needle-biopsy diagnosis, but today I believe that's inadequate because the amount of tissue obtained does not provide for determination of estrogen receptors? Is that correct, Dr. Holaday?

HOLADAY: That's right, Dr. Batley, it takes about 1 square cm of tissue for estrogen receptor determination.

BLAKEMORE: I believe, however, the use of excisional or needle biopsy varies, depending upon the pathologist. Most surgeons defer to the pathologist for the type of biopsy and amount of tissue necessary.

MOSKOWITZ: I think we have to start discussing the concept of determining the stage of the disease and the size of the tumor. My personal feeling is that when you are evaluating a small, early lesion with a ten-to-one chance of it not being cancer or that if it is cancer, the chances are great that it is an in situ lesion. The goal of treatment for carcinoma of the breast should be to be certain that the lesion has been removed. It is unwise to pressure the pathologist into a definitive diagnosis based upon a small, frozen-section specimen. He should be given the opportunity to spend whatever time is necessary to evaluate the tissue properly. I had a

recent experience with my colleagues at Memorial Hospital in New York. A physician's wife had a small lesion in the breast determined by mammography, had a biopsy, and the initial, frozen-section diagnosis was a benign breast mass. However, subsequent studies indicated that the patient had a carcinoma in situ, an area of ductal carcinoma, and lobular carcinoma with a small focus of microinvasion.

BLAKEMORE: The problem of mammography of the small lesion is to determine if it is completely excised and if the pathologist is examining the same area detected by mammography. The specimen removed should be x-rayed and compared with the preoperative mammograms to make sure that the abnormal tissue has been removed. Dr. Holaday, I would like your comments on specimen mammography.

HOLADAY: Specimen mammography is an integral part of the investigation of the small lesion detected by xerography. A small lesion is, by definition, one that is less than 5 cm in overall diameter; doing a frozen-section biopsy on a specimen this size presents a problem. First, the lesion may be destroyed by the frozen-section preparation and very little tissue left for fixed specimens. The biggest problem is trying to find the calcification or lesion seen on the film. A variety of techniques have been used, placing needles in the lesion and other methods, but I think frozen-section diagnosis under these circumstances is not worthwhile. We do specimen mammography and then take multiple blocks and sections of the area. We make new x-ray films of the specimen, being sure that we have the proper tissue for microscopic examination and that there are no other abnormal areas in the specimen. We make our initial slides, and if we don't see the suspicious lesion, we make an x-ray film of the paraffin blocks to determine if the calcification is still in the block rather than on the slide. It may take as long as two weeks before you are convinced that you have seen every significant lesion in the specimen.

MOSKOWITZ: We're in a new ball game. If we're going to find lesions early enough that removal can make a significant impact on a patient's survival, we must be patient and not be concerned about immediate diagnosis and treatment. Everyone concerned with the patient's problem should have a reasonable opportunity to make sure it is handled properly.

HOLADAY: I think frozen-section diagnosis of breast lesions will become obsolete in time but not in the immediate future. However, I think that as we detect small breast lesions with mammography, early lesions will be removed for which frozen-section biopsy would be inadequate.

MODERATOR: Dr. Batley, do you have a comment?

Adjunctive Chemotherapy in the Postmenopausal Patient

BATLEY: Yes, I would like to discuss whether this patient should be started on chemotherapy. She is postmenopausal. Is there any real evidence that multiple-drug chemotherapy will delay the onset of recurrence in this patient? She probably has occult, distant metastases. Is there any controversy concerning adjunctive chemotherapy under these circumstances?

MODERATOR: Yes, there is, Dr. Batley. A recent report indicates that adjunctive chemotherapy is of benefit in the premenopausal patient, but the results are less striking in the postmenopausal patient.[6] In premenopausal women, the most significant results are obtained in those individuals who develop amenorrhea while receiving chemotherapy. This suggests that hormonal factors may be playing a prominent role in the response to chemotherapy.

BATLEY: Is this an expensive way of producing castration?

MODERATOR: Yes, that's possible.

BATLEY: Is it of any benefit to a patient who is postmenopausal — in this instance, a 60-year-old woman?

MODERATOR: The data concerning L-Pam are clear. It is of no benefit in the postmenopausal patient. The CMF data in the postmenopausal patient are similar. I think one could be cautious about using chemotherapy in the postmenopausal patient with carcinoma of the breast. I think it reasonable to say that adjunctive chemotherapy in the postmenopausal patient using L-Pam or CMF has not produced a significant increase in survival.

BATLEY: Would you go so far as to say that it would be unwise to start postmenopausal patients routinely on an adjunctive chemotherapy regimen unless they are part of a controlled study from which we may gain additional data?

MODERATOR: Yes. As you know, oncologists feel that any patient receiving adjunctive chemotherapy for carcinoma of the breast should be informed that it is an experimental procedure. The patient should be given adjunctive chemotherapy only with her informed consent, and should recognize that it is an experimental procedure.[7]

The principal side-effects from chemotherapy are nausea, vomiting, leukopenia, and occasional thrombocytopenia. Loss of hair, cystitis, and stomatitis also may occur.

BLAKEMORE: This brings us to another phase of treatment which should not be overlooked — full explanation to the patient of the implications of her illness. The patient should be given an explanation of the implications of disease, the treatment, and the necessity for frequent examinations. When the patient has carcinoma of the breast, psychologic support for the family and the patient are most important, and it is necessary to continue this support when the patient's disease proves to be overwhelmingly and obviously terminal.

MODERATOR: This brings up the very important role of the primary care physician in managing these patients. The primary care physician must stay in contact with the patients and participate actively in their care during the period following mastec-

tomy. These patients require emotional support, and the family physician, who knows the patient and her family, can provide this type of psychologic support. The family physician should be fully informed about the treatment plan, the side-effects of the drugs, and be aware of the diagnostic procedures helpful in detecting recurrence. The primary physician's role is not completed when he detects a lump in the breast, makes the necessary diagnostic studies, and refers the patient to a surgeon for surgical therapy. He should take a very active role in her follow-up care.

Dr. Blakemore, I know this may be somewhat controversial, but I would like to ask what type of surgical procedure you would consider adequate for the patient we are discussing.

The Choice of a Surgical Procedure

BLAKEMORE: The procedure I would perform would be a conventional, radical mastectomy of the Halsted type. On the basis of the location of the tumor in the patient, there are some surgeons who would perform a resection of the internal mammary chain of lymph glands. Some surgeons would do this routinely as an extended, radical mastectomy. Much of the controversy concerning the type of surgical procedure to be performed for carcinoma of the breast is based more on emotion than on scientific data.

BATLEY: I'm stepping into this conflict. The Halsted radical mastectomy has been with us since 1895. I think it was introduced because Halsted had operated on approximately 30 patients. He followed up on only a few of these, but those cases he followed up did not develop a local recurrence. It seemed remarkable that an operation as radical as a Halsted mastectomy could survive so long on such slender evidence since less extensive operations provide results that are just as good. I think the Halsted mastectomy has served its purpose and that modified, radical mastectomy — and even less drastic procedures — are better operations.

I know this is a controversial area, and I'm stepping out of my field as a radiation oncologist, but I think that the morbidity is much less following the less-than-radical mastectomy.

HOLADAY: Dr. Batley, that's true only if you lump all stages together. In our own experience, we found that half of the patients with negative axillae did not benefit from radical mastectomy. However, 30 percent of these patients had axillae in which five or more nodes were positive, and did not benefit from the radical mastectomy either. Twenty percent of these patients derived all the benefit from a radical mastectomy because they had one, two, or three nodes; they had the same overall survival time as those individuals in whom the axilla was negative. Thus, in general, I agree with you. Eighty percent of the patients who had radical mastectomy derived very little benefit from the procedure. Again, I think this is a reflection on the inaccuracy of clinical staging. Radical mastectomy is the ideal surgical procedure for the patient with limited disease in the axilla.

MODERATOR: Dr. Blakemore, Dr. Batley has mentioned a modified radical mastectomy in which the pectoralis muscles are preserved. What about this procedure?

BLAKEMORE: There are surgeons who have performed this operation for many years. The important consideration is whether they take the time to realize the importance of adequately dissecting lymph nodes from the axilla. There is a difference in these two operative procedures. It is difficult to adequately expose the dome of the axilla with a modified mastectomy. It makes no difference in those individuals with no metastases — and you can't tell prior to the surgical procedure. Scientific proof of differences between a radical and a modified mastectomy is not yet available, but attempts are being made to collect these data. There are patients on whom we would perform a modified radical, eg, a patient with a lesion in the lower quadrant. The size of the tumor in this patient would dictate a more conventional procedure, and we would advise surgeons to continue to perform the conventional Halsted mastectomy and to remove all the axillary nodes.

MODERATOR: Is any surgical procedure worthwhile that does not evaluate the axillary nodes?

BLAKEMORE: We do perform simple mastectomies.

MODERATOR: Under what circumstances?

BLAKEMORE: For patients for whom the only goal is to remove the local disease. It's acceptable. We do this for older patients in whom there is no evidence of spread, the risk of operation high, and the benefits of the surgical procedure minimal.

MODERATOR: Dr. Batley, are there any patients in whom more can be accomplished with a simple mastectomy than with local radiation therapy? Is radiation therapy an alternative?

BATLEY: If the patient has a large, ulcerated, carcinoma of the breast with fixed nodes in the axilla, we generally administer local radiotherapy. You can control the local disease, get the ulceration to heal, and the nodes to diminish. If the patient is comfortable after completion of the radiation, no further therapy is necessary. However, if the mass is still present after completion of the radiation therapy, you can follow with a



Frank Batley, M.D.

simple mastectomy. It is remarkable how many of these older patients will live a considerable period of time without any problems after local radiation therapy. When there are two choices, one conservative and one radical, radiotherapy or surgery, and there is no strong evidence as to which is the better, I tend to use the conservative approach.

MODERATOR: I made the statement earlier that there seemed to be a distinct difference in the behavior of carcinoma of the breast in the *premenopausal* as compared with the *postmenopausal* patient. From the lack of comment, I would assume that most of the panelists agree with that.

BLAKEMORE: Yes. I would extend that comment further to say that in the very old patient, carcinoma of the breast is a different disease. It often is benign in the older age group.

MOSKOWITZ: There is an interesting game you can play with that statement. You can argue that carcinoma of the breast in an older woman improves longevity, simply because, in 20 years, relative survival exceeds absolute survival. They are going to die from some other cause before their cancer has a chance to kill them.

Follow-up Procedures

MODERATOR: Would you apply the same criteria for following up this case as for the 32-year-old, nulliparous woman? Would you do a mammogram once a year?

MOSKOWITZ: Radiologic follow-up for these patients with large, pendulous breasts is difficult. I think the mammographer will detect the lesions earlier than you will find them on physical examination. On the other hand, should we equate benefit with discovery? You are discussing a 60-year-old woman with an advanced lesion and metastases who is more likely to die from a stroke or a heart attack than from primary breast cancer. It will cost the patient $40 annually, and I don't think it is as necessary as it is in the younger woman.



Myron Moskowitz, M.D.

BLAKEMORE: The important point is that her case should be followed up on a regular schedule. The only question is whether to use mammography; the other follow-up examinations are mandatory.

BATLEY: I have checked up on a number of patients after radical mastectomy, and it is astonishing to me how few of them develop carcinoma of the contralateral breast. The American Cancer Society figures indicating it is five times more frequent in the remaining breast are surprising to me. I assume the figures are correct; in my experience, it seems relatively rare. Now, why should it be so rare? Whatever genetic and hormonal influences occur in one breast also occur in the other breast. So, frankly, my impression that it is relatively rare in the contralateral breast continues to apply.

MODERATOR: Doesn't it depend on histologic types? There are certain types of breast cancer in which the tendency to be bilateral is greater than others. Dr. Holaday, would you comment on this?

HOLADAY: If you check the files of our hospital dealing with a significant number of cases of carcinoma of the breast and put those cases in consecutive order, it is quite obvious that those women are developing contralateral disease. It becomes more obvious when you realize that five years after the initial surgery, half of these patients are dead — so there is no opportunity for them to develop a second carcinoma. If the American Cancer Society says this occurs in 12 to 13 percent of the time, you have to multiply that number by two because the other half had no chance to fulfill their destiny; and this is very significant.

MOSKOWITZ: The factor that Dr. Holaday used is precisely the factor that has been shown in cancers in Urban's experience and in the group at the Ellis Fischel Hospital in Missouri.[8-10] No matter what the histologic type, 23 to 25 percent of random biopsies will have a focus in the contralateral breast. The statement is made in a textbook on breast cancer that bilateral carcinoma of the breast must be very rare,[11] yet 5 percent of the breast cancers detected in our detection center are bilateral initially.

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Dr. Batley, Columbus, Director of Radiation Therapy, The Ohio State University Hospitals; Professor of Radiology, The Ohio State University College of Medicine; and Member, OSMA Committee on Cancer.

Dr. Blakemore, Toledo, Director of Surgery, Medical College of Ohio Hospital; and Professor and Chairman of Surgery, Medical College of Ohio at Toledo.

Dr. Holaday, San Antonio, Texas, Professor of Pathology, University of Texas Medical School at San Antonio. At the time of this forum, he was Professor of Pathology, The Ohio State University College of Medicine.

Dr. Moskowitz, Cincinnati, Attending Radiologist, University of Cincinnati Medical Center; Consulting Radiologist, Cincinnati Veterans Administration Hospital; Director, Breast Cancer Detection Center, University of Cincinnati; and Professor of Pathology, University of Cincinnati College of Medicine.

An impressive case is a patient with an obvious carcinoma in one breast and a small carcinoma in the contralateral breast. In the breast with the obvious carcinoma, 16 of 32 nodes were positive and, on the in situ carcinoma, 6 out of 12 nodes were positive. Obviously, the patient will not survive long enough for the occult carcinoma to become clinically overt.

HOLADAY: Dr. Berg in Iowa did some classic work on correlating the histologic types with outcome.[12] In his studies, he pointed out that the paient must be young, should not die of another disease, and should have no disease in the axilla. Under these circumstances, the patient has an 80-percent chance of surviving the initial carcinoma of the breast. Histologic varieties of breast cancer in this category are those with a very low incidence of metastatic involvement of the axillae, and include lobular carcinoma in situ.

Breast Cancer in the Perimenopausal Patient

MODERATOR: Let's discuss the next patient, a 51-year-old woman with a large, 3-cm firm, mass in the outer-upper-quadrant of the left breast. Axillary lymph nodes are positive; she has lost weight; and has low back pain. A routine check x-ray film shows osteoblastic metastases in the ribs. Obviously, this patient has stage IV disease, and we would like the panelists to comment on the management of her case. Dr. Blakemore, what about surgery on this patient?

BLAKEMORE: We should have further studies of this patient to see if the disease could be detected in other areas, such as the liver and the brain. After further evaluation with radiologic studies, one must confirm the diagnosis of breast cancer by tissue diagnosis and determine the estrogen-binding properties of the tumor. Since the patient has stage IV disease, the initial procedure would be an excisional biopsy of the breast mass.

BATLEY: The patient has obvious, extensive bone metastases. Isn't that right?

MODERATOR: Yes, that's correct.

BATLEY: I would propose some form of chemotherapy or hormonal manipulation. I would hold radiation therapy in reserve, but the most effective treatment for painful metastases is local radiotherapy.

The breast mass may respond to chemotherapy or hormonal manipulation and be a good objective guide to the effectiveness of the treatment. On the other hand, I would caution the chemotherapist not to allow the tumor to grow in the face of chemotherapy because I have seen tumors progress even though the patient appears to be on an effective chemotherapy regimen. Radiation therapy could be used subsequent to chemotherapy. The radiation therapy would be much more effective if chemotherapy reduced the breast mass. Radiation therapy for a huge, fungating carcinoma of the breast is most difficult. I would recommend radiation therapy to the painful areas of the skeleton. If the patient should develop ulceration of the breast mass, and it does not respond to chemotherapy, localized radiation therapy would be beneficial. Radiation therapy for this patient should not be overlooked for local, painful areas in the skeleton or for enlarging or fungating lesions of the breast.

The Evaluation of Ovarian Function

MODERATOR: This patient's case is a problem because of her age. Dr. Blakemore, how would you evaluate the status of ovarian function? Let's assume that her periods have been irregular for the past year, and she has not been having regular menses. Would you assume that she is menopausal and proceed on that basis, or would you rely entirely on results of the estrogen-binding studies on the tumor?

BLAKEMORE: We would evaluate ovarian status by vaginal cytology and, if available, hormonal assays on 24-hour urine specimens. Other than local disease, her treatment would be pretty much the same, whatever her ovarian functional status, and the determination of estrogen-binding sites would be of value in terms of prognosis.

MODERATOR: One of the helpful guides to ovarian function, particularly in the perimenopausal group, is an immunoassay for serum follicle stimulating hormone (FSH). A high FSH level indicates diminished-to-absent ovarian function and low levels of active ovarian function.

BATLEY: In patients with bone metastases, the physicians of Princess Margaret Hospital in Toronto, Ontario, Canada have used half-body radiation, a technique that was suggested by Dr. William Rider of Scotland.[13] Dr. Rider had a patient whom he was treating every week, and she would come in with a different metastatic site of involvement in the pelvis, femur, and other areas. Finally, the patient asked Dr. Rider, "Why don't you treat all of me instead of having me come back every week or so?" He told her, "You know, that's a tough thing to do. With whole body radiation, half the patients die with 300 rads." She said, "I wouldn't like that." So he decided to compromise and treat half of her body. The lower half of her body, which contained most of the metastases, was treated with 800 rads in a single exposure. She had some side-effects, but they were relatively mild. A month or so later, he treated the upper half of her body with 800 rads. With this regimen, she had good palliation of her bone and skin metastases, and Dr. Rider has continued to use this technique. The reason this therapy isn't fatal to patients is because of the limited myelosuppression. When you treat the patient with chemotherapy, you are depressing all the bone marrow but with selective radiation therapy, you localize the effect of your chemotherapeutic action because radiotherapy is a method of delivering chemotherapy to the tumor. You deliver chemotherapy to the area of radiation effectively. When you radiate the lower half of the patient's body, you reduce marrow function in the area radiated but you also destroy a lot of the cancer and the bone marrow and the untreated portion of

the body is not affected. In the interval between the first and second course of treatment, the untreated marrow repopulates the treated area in the lower half of the body and marrow function is restored. Dr. Ryder has been very enthusiastic about what appears to be a very simple treatment regimen.

MODERATOR: Would it be reasonable to assume that oophorectomy would be performed on this patient if she had evidence of estrogen binding in her tumor? It is important to note that it takes approximately three months to determine response to oophorectomy, as far as regression of metastases is concerned. If the patient has a favorable response to oophorectomy and then shows progression of the tumor, other endocrine procedures, such as adrenalectomy, can be considered. Dr. Blakemore, would you comment on adrenalectomy. Have you done this procedure, and do you think it's of any benefit?

BLAKEMORE: An adrenalectomy has been helpful in selected patients, particularly those with osteoblastic metastases, such as this patient, and especially those who responded to previous endocrine manipulation. Patients who do not respond to oophorectomy do not respond to adrenalectomy. In my experience, it seems to be about equal value with oophorectomy and hypophysectomy.

MODERATOR: Would you agree that if this woman had an oophorectomy at the end of 90 days and still was having pain with no evidence of objective response, she would not be a candidate for adrenalectomy?

BLAKEMORE: Yes. Barring new information, such as that concerning the estrogen-binding sites of the tumor, she probably would not have a beneficial response to adrenalectomy.

MODERATOR: Hopefully, in the not-too-distant future, anti-estrogens will be available in this country for the control of hormonally responsive tumors. I think we all agree that this patient would be a candidate for endocrine manipulation and, based upon further data, an oophorectomy. However, there could be some difference of opinion as to whether this could be accomplished by surgical extirpation or by radiation. One of the problems in management is whether measures in addition to endocrine manipulation should be considered. In my own judgment, I think the patient with bone metastases only, and no evidence of disease in the brain, lung, or liver, it is worthwhile to observe the effects of endocrine manipulation without concomitant chemotherapy. However, when the liver, lung, or brain is involved, I think that chemotherapy should be given concomitantly.

If the patient is treated by endocrine manipulation alone, and has a favorable response, chemotherapy should be instituted at the time of relapse.

This woman has incurable disease, and the quality of life depends a good deal on the attitude and support of her physician. Dr. Blakemore, would you comment on your approach to this type of patient, what you tell her about the disease, and what you think is important in terms of information necessary for her to make reasonable decisions regarding her lifestyle.

What to Tell the Patient

BLAKEMORE: Within the limits imposed by bone metastases — the possibility of pathologic fractures — the patient should be encouraged to follow a normal lifestyle. These patients may have long survival with regression of the symptoms following endocrine manipulation or chemotherapy. The quality of life can be good and the life expectancy reasonable, certainly longer than what most people have anticipated with metastatic carcinoma. I think that the long-term outlook should be one of cautious optimism and the patient should be encouraged to return to her normal lifestyle if possible.

MODERATOR: Dr. Blakemore, what would be your approach to this problem? What would you do if the patient's husband came to you and said, "She is a very nervous person and has been very depressed in the past. I am afraid that if you tell her that she now has spread of her breast cancer, she will become so depressed that she will be nonfunctional." Under these circumstances, would you tell the patient that she has metastatic breast cancer?

BLAKEMORE: I usually assume that the family knows the patient best, but I must test their thesis by asking the relatives if they really want to handle the matter that way. I point out that, in the long run, it is better to be honest and open with the patient. It will produce the best relationship between the patient, the family, and the physician.



William J. Holaday, M.D.

MODERATOR: Dr. Batley, do you ever encounter patients who wonder why they are receiving radiation treatment?

BATLEY: The majority of our patients have been told that they have cancer. However, I encounter patients who are nervous and worried. I tend to talk about "good" cancers and "bad" cancers, and I point out that I have known patients who have lived years with metastatic disease and carried out their normal occupations. I explain that no one can predict the future and that some cancers regress spontaneously. The diagnosis of cancer certainly is not a sentence of doom. I try to give the patient a bit of hope. If she is feeling well, I say, "this is obviously because your cancer is acting in a benign way." If you

talk to the patient long enough, she can be cheered by an optimistic approach, but still you have to be honest. You can't be overly optimistic since unbounded optimism may lead to disaster when the tumor progresses.

BLAKEMORE: We have reasons to be optimistic about the treatment of carcinoma of the breast, though we have to realize that we are not changing the incidence of the disease. With the exception of recent data on the use of adjunctive chemotherapy, we're probably not changing significantly the survival of patients with carcinoma of the breast. It still remains a medical challenge, and we are not making the progress we would like.

MODERATOR: How can we speed up progress?

BLAKEMORE: We hope that early detection will result in significant improvement; that combined chemotherapy will be helpful, particularly for the premenopausal patient; and that new modalities of treatment will be developed. Immunotherapy is still experimental, but no one will deny that host resistance is a major factor in determining the course of disease. Perhaps if we could manipulate the immune response, we could control recurrent disease. Obviously, we need more research, better protocols for adjunctive treatment which will provide us with the necessary data to determine optimum treatment for breast cancer. We need new knowledge about the phenomenon of cancer in general and breast cancer in particular.

Summary

MODERATOR: Perhaps it is time to summarize our discussion. We have considered three problems: a young, a middle-aged, and an older woman with carcinoma of the breast. In each instance, the stage of the disease was different and treatment plans differed. Dr. Moskowitz, would you summarize the contribution of diagnostic radiology in a breast cancer?

MOSKOWITZ: Dr. Blakemore has stressed what I think is the key point in improving the potential for survival, and that is physical examination. Diagnostic radiology has very little to contribute in evaluating the patient with a palpable mass. It is a matter of arithmetic and mathematics; if you study national data of survival rates in breast cancer, you find it has been essentially stable for the past 50 years. A patient with stage I carcinoma of the breast has a five-year survival of 65 percent; stage II overall survival is 29 percent. Based on the data available, it is reasonable to assume that patients with in situ, minimal disease have a survival of about 80 percent in 20 years. If we could discover 100 percent of the cases of stage I, we could improve the survival rate from 47 percent to 65 percent. On the other hand, when we locate an in situ breast cancer, we can improve survival to 90 percent. Obviously, we cannot accomplish this, but an aggressive approach to early diagnosis can increase the percentage of patients with minimal disease and, therefore, decrease the number of patients with stage II disease. Using the methods of diagnosis available today, we can reasonably estimate a significant improvement in the 20-year-survival of patients with breast cancer. I offer this statistical explanation of the value of early detection to emphasize that an aggressive approach is mandatory in the patient with minimal findings. In my opinion, the laissez faire attitude toward breast abnormalities has prevailed too long. I suggest that watchful waiting is not a conservative, but a very radical, approach. The conservative approach may very well be to biopsy a minimal lesion.

BATLEY: I would like to emphasize that radiotherapy is most effective when you treat local areas to a high dose of radiation. It can be used to treat minimal, early disease. If you treat large volumes, you are interfering with the immunity of the patient and may make him worse. Radiation treatment is palliative for distant metastases, such as bone metastases. I would emphasize that you treat local areas for pain and that caution should be used in the therapeutic approach. Sometimes a treatment may be more troublesome than the disease. To further clarify my feeling about local treatment, I would say that, as a rule of thumb, any tumor smaller than a cricket ball can be controlled by radiotherapy, but with any tumor larger than a cricket ball, you are using radiotherapy palliatively and you should use radiation cautiously.*

MODERATOR: Dr. Blakemore, do you have any further comments?

BLAKEMORE: Surgery is still the primary treatment for carcinoma of the breast, and the role of the surgeon is to increase early diagnosis. Hopefully, the combination of adequate surgery with adjunctive therapy will significantly increase survival of patients with this disease.

MODERATOR: Thank you, Dr. Blakemore. Dr. Holaday, the pathologist always has the final comment.

HOLADAY. Predictably. Pathology, and I include laboratory medicine, has three contributions. The first is to confirm the diagnosis by whatever means the tissue is obtained, by aspiration biopsy, needle biopsy, or excisional biopsy. The second contribution is the determination of estrogen receptors; and the third is to provide the information necessary for adequate staging. Assessment of regional nodes, the result of a meticulous dissection and examination of the specimen, is vital for prognosis. The pathologist has an integral role in the team approach to the identification of the small, in situ carcinoma and must work closely with the radiologist and the surgeon in evaluating these lesions.

BATLEY: Dr. Holaday, how often do pathologists make false-positive diagnosis of carcinoma of the breast? One of the reasons that our results in treating carcinoma of the breast

*Please contact Dr. Batley, Department of Radiation Therapy, The Ohio State University Hospitals, 410 West Tenth Ave., Columbus, Ohio 43210, for the exact dimensions of a cricket ball.

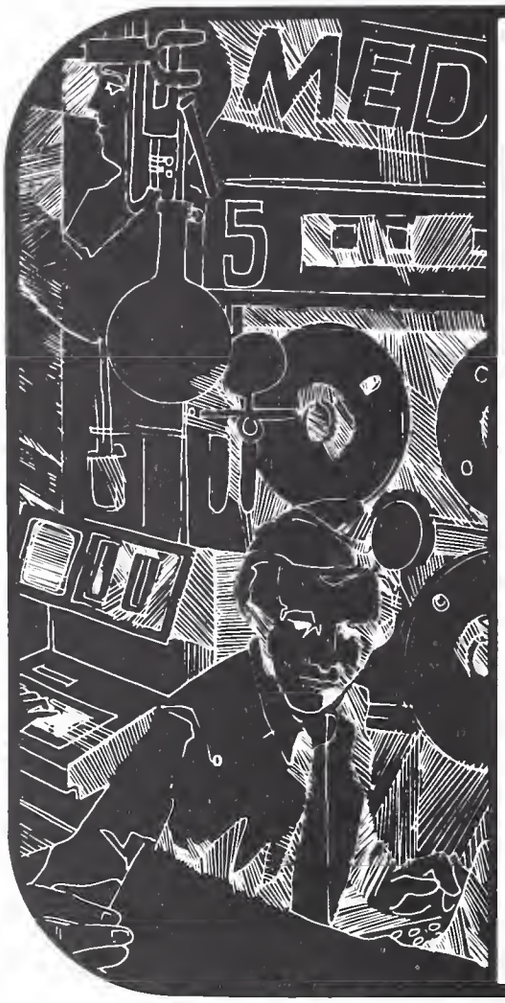
are improving is that lesions formerly not regarded as cancer now are considered to be such. I know one pathologist who stated, "the only way you can really be sure the patient has a carcinoma of the breast is if they develop metastases or die of the disease."

HOLADAY: Obviously, your question is difficult to answer. The definition of a malignant neoplasm is one that metastasizes. My own personal experience is that false-positive diagnosis of breast cancer is rare.

MODERATOR: Thank you gentlemen, for your comments.

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Each of the following questions refers to the article "Carcinoma of the Breast," which appears on page 677 of this issue of The Journal. Circle the correct answer:

1. A 32-year-old nulliparous woman consulted her physician concerning a lump in her right breast which she had noted for two weeks. She had taken anticontraceptive pills for one year. The mass was 1.5 cm in diameter and in the upper quadrant of the right breast. Which of the following is most appropriate?
   A. Admit to the hospital at once for excisional biopsy.
   B. Discontinue anticontraceptive pills. Return for examination in one month.
   C. Obtain xeromammogram of both breasts.
   D. Discontinue anticontraceptive pills; reassure patient; reexamine in six months.
   E. Obtain further history concerning parity, family history. Return in one month for reevaluation.

2. A 40-year-old woman has a firm nodule in the inner-lower quadrant of the left breast which she thinks has enlarged. Her case has been followed for several years for fibrocystic disease of both breasts and nodules have been palpable previously. A mammogram six months previously showed no abnormalities. The nodule is 2 cm in diameter and much the largest in a multinodular breast. The most appropriate approach is:
   A. Repeat mammogram; if any abnormality, biopsy.
   B. Review previous mammogram; evaluate lesion monthly if previous mammogram not a false negative.
   C. Arrange for excisional biopsy.
   D. Repeat mammogram and plan excisional biopsy, regardless of findings on mammography.
   E. Admit to hospital for breast biopsy, bone scan, and bone marrow biopsy.

3. A 20-year-old woman consults you for advice about mammography. Which of the following factors would necessitate annual mammography in a woman less than 35 years old?
   A. Multiparous
   B. Large pendulous breasts
   C. Positive family history of breast cancer
   D. Late-onset menstruation
   E. Obesity

4. The determination of estrogen binding by a breast tumor:
   A. Is a research procedure.
   B. Should be made on all breast tumors.
   C. Is of value only in premenopausal women.
   D. Is helpful in predicting response to adrenalectomy.
   E. Is of value in predicting response to oophorectomy but not to the use of estrogens.

5. Radiation therapy is most appropriate for:
   A. Postoperative to axilla in patient with positive nodes.
   B. Preoperative to large bulky tumors.
   C. Prophylactic to operative site if axillary nodes are positive.
   D. Internal mammary nodes of all patients with inner-quadrant lesions.
   E. Any isolated, bulky mass of breast cancer tissue.

6. Adjunctive chemotherapy for breast cancer is indicated in which of the following:
   A. Premenopausal woman with negative axillary nodes.
   B. Premenopausal woman with 18 of 24 positive nodes.
   C. Postmenopausal woman with 2 of 20 positive nodes.
   D. Postmenopausal woman with negative axillary nodes.

7. Which of the following is the most important risk factor in the development of carcinoma of the breast?
   A. Age
   B. Parity
   C. Family history
   D. Use of estrogens
   E. Chronic breast disease

8. Which of the following is true concerning thermography of breast lesions?
   A. Supplements mammograph in screening.
   B. More sensitive than mammogram.
   C. May be of value in prognosis.
   D. Negative in inflammatory breast lesions.
   E. Best single screening technique for early breast cancer.

9. Which of the following are the minimal procedures to be performed prior to a mastectomy for breast cancer?
   A. Chest x-ray, biochemical profile, liver scan.
   B. Chest x-ray, biochemical profile, metastatic bone survey.
   C. Chest x-ray, biochemical profile, bone scan.
   D. Chest x-ray, biochemical profile, bone marrow biopsy.
   E. Chest x-ray, biochemical profile.

10. Which of the following is true concerning a modified radical mastectomy?
   A. A simple, less complicated operation than a radical mastectomy.
   B. Provides adequate evaluation of axillary nodes.
   C. Lymphedema of arm occurs with same incidence as with radical mastectomy.
   D. Operation of choice for stage IV breast cancer.
   E. Functional limitation of arm and shoulder same as with radical mastectomy.

Questions 11, 12, and 13 concern the following patient.

11. A 60-year-old woman has a radical mastectomy at age 56 years. She now has a local recurrence and low back pain. Which of the following would be *least* helpful in evaluation:
   A. Biopsy of local recurrence with determination of estrogen binding
   B. Metastatic bone survey
   C. Bone scan
   D. Liver scan
   E. Mammogram of contralateral breast

12. A biopsy of a local lesion in this patient revealed the presence of estrogen receptors. Based on this data, which of the following would be most appropriate:
   A. Adrenalectomy
   B. Diethylstibesterol, 15 mg/liter
   C. Oophorectomy
   D. Hypophysectomy
   E. Testosterone administration

13. Bone scan in this patient was positive and no other lesions were demonstrable, other than the small nodules at the site of the previous mastectomy. Further management should include:
   A. Radiation therapy to local lesions on chest wall
   B. Radiation therapy to painful areas of skeleton
   C. No further therapy until response to endocrine manipulation determined
   D. Chemotherapy with CMF
   E. Surgical excision of nodules on chest wall

14. Which of the following is the most important factor in determining prognosis in primary breast cancer?
   A. Age at onset of disease
   B. Histologic type of cancer
   C. Family history
   D. Status of axillary lymph nodes
   E. Location of lesion in breast

15. The estimated number of new cases of carcinoma of the breast annually is
   A. 900,000
   B. 9,000
   C. 90,000
   D. 82,000
   E. 50,000

16. Which of the following is *not* true concerning physical examination of a patient with carcinoma of the breast?
   A. Inner-quadrant lesions are associated with metastases to internal mammary nodes.
   B. Fixation to skin is a sign of a malignant tumor.
   C. Fixation to pectoral muscle is indicative of a malignant tumor.
   D. Most breast cancers occur in outer quadrants of breast.
   E. Physical findings of early breast cancer are characteristic and clearly different from benign lesions.

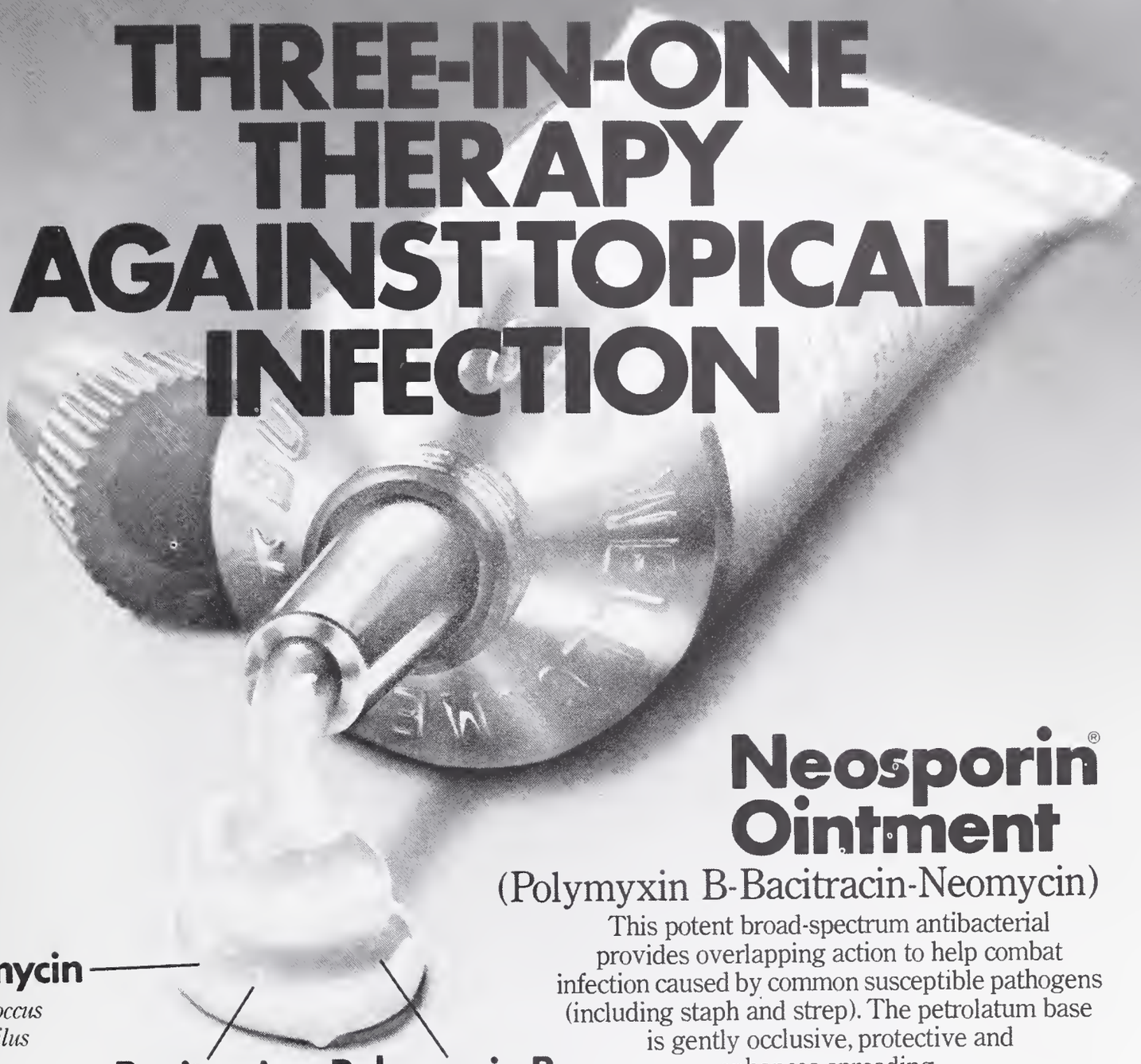
17. A 42-year-old woman had a radical mastectomy for breast cancer. Ten of 15 nodes were positive. The patient's husband requests that the diagnosis be withheld from the patient. The most appropriate approach would be:
   A. Accede to husband's request. Tell patient chemotherapy should be given to *prevent* development of cancer.
   B. Accede to his wishes. Inform the patient she has benign breast disease and that no further therapy is necessary.
   C. Accede to husband's request and tell patient x-ray therapy should be administered to prevent development of cancer.
   D. Refuse to withhold information from patient. Advise husband to find a physician who will accede to his wishes.
   E. Inform husband tactfully of necessity for further treatment and impossibility of dealing with patient adequately if she is not fully informed.

18. Which of the following is true concerning carcinoma of the breast in postmenopausal women:
   A. Less positive for estrogen receptors than in premenopausal women
   B. Increased incidence of lobular carcinoma
   C. More aggressive disease
   D. More benign and slowly progressive
   E. Rarely occurs in pendulous breasts

19. Which of the following is true concerning adjunctive chemotherapy:
   A. Most effective in postmenopausal women.
   B. Well-established treatment which prolongs survival.
   C. Considered experimental at present.
   D. No long-term side-effects occur.
   E. Should always be used when lymph nodes are negative for metastases.

20. Which of the following is the most important factor in determining the choice of surgical procedures for breast cancer?
   A. Cosmetic effect
   B. Prevention of lymphedema
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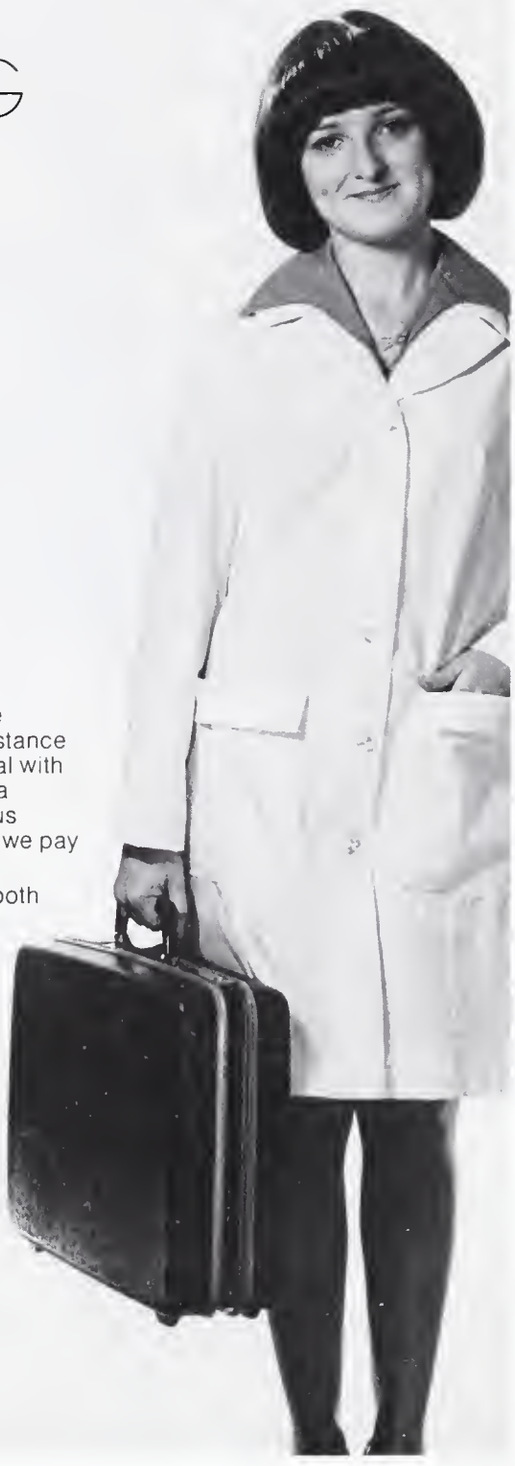
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The Psychiatrists' Influence on Other Physicians

Irving L. Berger, M.D.
Oscar B. Markey, M.D.

As part of the program established in the late 1950s by the National Institutes of Health, a course was initiated at Mt. Sinai Hospital in Cleveland. The purpose of the course was to familiarize physicians other than psychiatrists with the current concepts of treatment of psychiatric problems. Groups were formed with the main objective of helping nonpsychiatrist-physicians develop concepts and skills applicable to their daily practice without requiring them to become psychiatrists. The dynamics of the group process and the nature of the influence of the psychiatrist-leader played a central role in the 11 years this program was in effect. Meetings were held at regular intervals, usually weekly, with the number of participants limited to a maximum of 15. When the program was terminated in 1971, a questionnaire was sent to those who had attended for periods varying from ten weeks to several years. The physicians agreed generally that they had learned a great deal about dealing with patients' emotional problems and had developed a better understanding of the possible differences between the roles assigned them by patients and the roles they can assume.

Thirty-eight courses were given from December 1960 through December 1971, and 131 physicians, including general practitioners, internists, and osteopaths, attended 431 sessions.

FOLLOWING THE END of World War II, there was an upsurge of interest in the treatment of emotionally disturbed patients by helping nonpsychiatrist-practitioners via group sessions with psychiatrists. Well-established programs had been developed in a few general hospitals for inpatient as well as outpatient psychiatric care. The National Institute of Mental Health had developed a nationwide program for groups of medical practitioners, especially those now known as "primary physicians." Emphasis was placed on the practitioner's resumption of the role of the family doctor with concerned responsibility for the total emotional, social, and physical health of the patient.

There was a wide range of programs, from the essentially didactic to the more psychoanalytic approach used in the University of Pittsburgh program, which was influenced by the classic work of Balint with physician groups.[1] These programs undoubtedly have influenced the establishment of family practice training programs in an increasing number of medical schools. In our program, the groups assumed added responsibility for content as they gained stature in their professional self-images. The level of their approaches was self-determined and eclectic. It was hoped the physician would develop both a better understanding of the emotional elements in illness and of the relationship between physician and patient, thereby increasing the physician's professional self-confidence.

These courses covered a period of 11 years, with a total of 431 sessions attended by 131 physicians. As noted in Table 1, the largest number of attendants was in the

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Presented at the 129th meeting of the American Psychiatric Association, Miami Beach, Florida, May 10-15, 1976.

Submitted March 17, 1977.

TABLE 1. Attendance at Psychiatric Courses (431 Sessions) From December 19, 1960 Through December 6, 1971

Type of Practice	Number
Family practice	51
Internal medicine	24
Osteopathic	23
Pediatrics	5
Orthopedic surgery	4
Dermatology	4
Podiatry	4
Oral surgery	3
Allergy	3
Gynecology	3
Ophthalmology	2
Surgery	1
Proctology	1
Radiology	1
Gastroenterology	1
Dentistry	1
Total	131

area of primary medical responsibility (general practitioners, internists, and osteopaths). There were only two surgeons who, as a group, might be expected to have lesser interest in the nuances of the physician-patient relationship.

The initial program dealt with recognizing the fact that many physicians had little training in understanding the nature of individual adjustments; their medical school experience often lacked dynamic psychiatric training. Physicians, trained in the medical model, learned to seek cause and effect and to search for tissue pathology while in medical school. The ambiguities and uncertainties of the human condition seldom were given studied consideration; they were treated almost as noxious elements contaminating the physician's therapeutic efforts.

Whitehorn[2] comments that physicians can apply intuitively what they have learned through experience with other human beings as their basis for professional understanding and performance. However, the intuitive perception that the patient himself may function as a pathogenic agent may provoke impatience and rejection on the part of the physician. This resembles the reactions of the laity at large, who are unsympathetic with those who suffer varying degrees of emotional illness, especially the openly irritating type.

Our goal was to help the physician gain knowledge of the nature of individual psychologic functioning, thereby enabling him to be more tolerant of the uncertainties and the variety and differences in patterns of adjustment to illness. This goal was best served by early presentation of case material from the physicians' own practices. The physician was encouraged to present pertinent cases from his practice for discussion. This resulted in a learning experience emanating from mutual sharing and revealing underlying attitudes, biases, and the physicians' subjective reactions. Ten to 15 physicians moved into an advanced program for ten weekly sessions, and several of these remained through the entire program.

In the introductory sessions, we presented didactic material on such topics as personality development, psychosexuality, problems of adolescence, young adulthood and aging, neurotic and character disorders. The acute psychiatric emergencies, including suicide attempts, psychotic reactions, and alcoholism, also were discussed in the beginning sessions. It was our belief that such a framework for further learning was essential, inasmuch as few of the participants were knowledgeable in basic psychiatry. On occasion, the participating physician would ask one of his peers to interview his patient and to share in the definitive discussion that followed.

Video tape equipment was available later for direct interviewing of the patient by the physician in the presence of the group. Subsequently, this video tape material was replayed and utilized, particularly to help the physician develop his interviewing technique and to foster a better understanding of the interactions between patient and physician. The patients appeared quite willing to become involved in such a program, on the basis that they would be deriving some benefit from consultation with a peer group of physicians. We learned that a physician often could profit from interviewing another physician's patient. The interviewing process itself was more than just an intellectual challenge; the interviewing physician often was helped to see his own subjective approach more clearly.

Table 2. Courses Attended (Ten Sessions Each) and Number of Participants.

No. of Courses	Participants
1 only	78
2 to 3	33
4 to 10	11
11 or more	9

Problems of Recruitment

Initially, the courses were limited to the staff of Mt. Sinai Hospital through a grant by the National Institute of Mental Health. A questionnaire soliciting interest in such a course was mailed to the hospital medical staff; and the first course was started with approximately 15 physicians, about 25 percent of those who initially expressed interest in the program. Members of the group encouraged others to join future courses which eventually included other physicians in the community. Eventually, this involved a combined sponsorship with the Cleveland Academy of Medicine. Later, when the Ohio Academy of General Practice became involved in fostering the program, as many as three courses were given concurrently in various parts of the community. The results were best when a primary physician accepted recruiting responsibility for fellow members of his hospital staff. Some physicians objected to attending weekly sessions, and some were interested in a one- or two-day program. We saw this as a way of stimulating an interest in longer courses. Not all physicians appreciate the advantage of participating—they prefer to partake. The short programs were largely didactic in nature.

The psychiatrist occasionally met with physicians in consultations or at general meetings, in the hope of helping them see the psychiatrist as someone who could offer psychiatric views that would be useful in their daily practice.

We were able to recruit about 5 percent of the total number of physicians in the community, perhaps less than we expected. Most were general practitioners and internists who normally are involved in the total family situation and who need to develop a longitudinal follow-up of their patients. These physicians are more apt to be involved in more personal problems in their full care of families.

Some physicians gradually developed confidence in psychotherapeutic work with their patients by scheduled appointments. This was more apt to occur if the physicians had attended more than three courses. Two groups were active over a period of five years. They explored in greater depth their understanding of the doctor-patient relationship, the psychodynamics of patients' reactions to illness,

and were better prepared to assume responsibility in the learning process.

Use of the peer group in the interaction between members was deemed helpful in assisting the physicians to perceive their role with their patients as well as clarifying some of the transference and counter transference problems.[3-5] At first, the group expected the psychiatrist-leader to offer essentially didactic material to fit in with their evident dependency needs. Their feeling of inferiority regarding their lack of knowledge of psychiatry often provoked, and was the basis for, increased dependency demands at first, but they encouraged opposition trends as their fears lessened later on.[3] Reflective of this need were questions such as: "How does one do such and such with a patient?" or, "How does one deal with an angry patient?" Usually, they considered such questions as practical measures that they could employ and representing difficulties in exploring the emotional basis for such reactions within their patients. The assumption that the psychiatrist-leader is omniscient was pronounced at first. This led to some anxieties surrounding the frustration of their evident dependency needs.[3,6] It was thought that the introductory didactic sessions at first provided emotional "food" to meet these needs. The physicians gradually learned that they needed to understand the nature of emotional factors in illness and that they could help the patient by getting him to share responsibility for his treatment. The task of "working with the patient," in contrast to "doing something for him," was a difficult hurdle for many of the members to surmount.

The physician's basic attitude toward himself and his role as a physician was given early and ongoing emphasis.[6] Some physicians' need for omnipotence and omniscience often evoked irritability and resentment on their part when the patients raised doubts about the doctor. This often produced the classic challenge between the doubting patient and the fragile narcissism of the physician, sometimes causing a break in therapy. The group was helped to explore the patient's infantile concept of the physician as a parental surrogate endowed with magical powers of healing and omniscience. The peer group, especially those who continued well beyond the introductory course, was able to discuss and understand such issues.

Dependency on the psychiatrist leader lessened as group cohesiveness increased. There was more sharing among themselves and with the leader, with obviously less resistance. The psychiatrist-leader served as a model with whom they could identify as they experienced and perceived his way of coping and dealing with patients. Problems arose at times as a result of identifying with the psychiatrist, such as when they attempted to emulate him in dealing with their patients with denial of their own ego. Most group members could perceive this and often helped a fellow physician develop his own particular style with his own limits and capacities. This was more apparent in those who remained longest as they developed major changes in their ability to deal with patients.

Learning certainly was enhanced through the experiential as well as cognitive elements of the course. Essentially, cognitive learning was demanded initially and obviously was needed, but they soon learned that they gained more through experiences with clinical cases discussed openly. The physician could bring his experiential difficulties in dealing with certain patients to the group; these issues often were clarified through group discussion.

As the physicians became less defensive, their less obvious personal problems often surfaced, but the psychiatrist-leader avoided analytic intrusion into their personal histories. No effort was made to deal therapeutically with more personal problems. It seemed sufficient for a physician to recognize them, especially since they might influence relationships with his patients. As the physicians' attitudes changed, they became less fearful of the more severe conditions, such as psychosis, suicide, and paranoid reactions. They learned to explore family problems without being openly intrusive and, thus, were able to deal more effectively with the family constellations. Through understanding some of their own limitations, they learned with which patients they could work best. They learned why they couldn't succeed with patients they did not like. Some physicians found they could deal more effectively with demanding, infantile patients because they had strong needs to nurture and protect, whereas other physicians became impatient with such individuals because of the threat to the doctor's omnipotence role.

The physician's specialty often was seen as a strong influence. For example, surgeons were more inclined to want to do something and tended to see their task as completed with surgery, while the internists and general physicians showed a tendency to observe and wait, and to share the therapeutic responsibility.

Two members subsequently went into formal training in psychiatry. A pediatrician devoted a substantial part of his practice to dealing psychotherapeutically with the families of patients, and another physician utilized his family practice to deal with family groups. Several others offered specific psychotherapeutic sessions, sometimes with consultation or assistance from the psychiatrist-leaders.

Psychiatrist's Role

By his investigative, inquisitive approach, the psychiatrist was helpful in clarifying some of the interactions between doctor and patient, as well as some of the underlying psychodynamics of patients' reactions. Surface reactions, such as resentment and anger, anxiety, flight, or excessive demands upon the physician were seen as challenges to investigation. The psychiatrist was able to show that such reactions were manifestations of underlying anxieties accessible to psychotherapy. This was particularly helpful in treatment of hospitalized patients, where nurses' reactions, nursing care, and issues surrounding the patients' denial mechanisms or regressive elements in response to their illness needed to be understood. The psychiatrist could be seen as an effective moderator of group discussion, as in discussing underlying psychologic mechanisms. Through identification with the psychiatrist, many of these physicians learned how to deal more effectively with regressive dependency, attempts to deny illness, and aggressive behavior. Earlier, these reactions might have

prompted counterreactions of impatient rejection or authoritarian dictates on the part of the physician. Of course, the leader gained medical knowledge from the group and the advantages were mutual— members and the leader learning from each other in a joint educational effort.

Case Examples

1. A physician reported difficulty in working with an 18-year-old adolescent, who appeared to be a ruminative, obsessive-compulsive individual preoccupied with numerous somatic concerns. Obsessive doubts regarding his adequacy and obsessive-compulsive, ritualistic orderliness were seen eventually as part of an underlying schizophrenic process. He was markedly withdrawn, a "loner," but he was concerned enough about his perfectionist study habits and fears of failure to seek help. Initially, the physician desired to place the patient under the definitive care of a psychiatrist. However, after the youth was seen by the psychiatrist, the physician became confident that he could help the patient, having been the family physician for many years. He knew the family dynamics well, and the study group encouraged him to furnish support to the youth's underlying needs. He reviewed the case with the group periodically or consulted with one of the psychiatrist-leaders. In contrast to his initial anxiety about dealing with a psychotic patient, this physician was able to treat this patient very effectively for several years.

2. Another physician had a special interest in treating obesity. The group helped him to recognize his need for patients to be obedient to him, revealing his oral-sadistic attitude at times by berating patients for not following his dietetic regimen. He himself had been obese once and had lost much weight through *APL* hormone treatment. He used this therapy more effectively with patients who were able to tolerate his authoritarian approach. He acknowledged this intellectually, but he did not alter his practice although recognition of this transactional pattern helped him to modify some of his impatience and irritability when he met with failure. His defenses were too strong to permit much change in attitude, and the group made no attempt to exert pressure on him.

3. In many cases, the group recognized somatic complaints as masking underlying feelings of depression. A physician presented the case of a middle-aged man who was preoccupied with such somatic complaints as heaviness in his chest and weakness of his arms for which no physical explanation had been found. The group helped the physician to elicit data revealing the patient's anxiety about retirement, his feelings of loss and lack of usefulness. This was the basis for his underlying depression and his presenting somatic complaints. Treatment of the depression was seen as essential. Although the outlook appeared rather guarded, further search for physical explanations was not required, and the patient was able to maintain an ongoing relationship with his physician.

What Did the Participants Gain?

A multiple-choice questionnaire was sent to all participants in 1972, a long time after the courses had been discontinued. Only 15 percent of them responded to the questionnaire, which included a brief examination of the participant's knowledge of psychiatric principles, clinical problems, and methods of treatment. Of those who replied, they proved best in their understanding of the doctor-patient relationship and how this affected their clinical approach. They did not perform as well on matters of didactic content, which we felt was of lesser significance in terms of our stated goals for the physicians. Essentially, it was not our goal for them to become proficient psychiatrists but rather to deal more effectively with the kinds of patients they would meet in their medical practice. Many of these physicians became able to provide supportive care for psychotic or borderline psychotic patients, to assist in the resolution of family problems, and to deal more effectively with patients with more benign psychiatric conditions. Several of them undertook more definitive care of many of the psychiatric problems they formerly had referred to a psychiatrist or a hospital facility. They felt they had developed a greater tolerance for patients' troubled attitudes; they were more confident of their ability to cope with diverse problems.

Another set of questions was directed toward evaluating the participants' reasons for entering the course, or for continuing it or dropping it, and what they believed it had done for them in terms of their professional self-image. Some reported they learned much more from the group experience per se than from the content— that only experience had helped to incorporate the content. Cognitive learning in itself is insufficient — it grows optimally through appropriate application. The practitioner certainly needs an adequate supply of facts and knowledge in the medical field, yet he needs to be able to apply this in a meaningful way in his relationships with his patients. The latter type of orientation emphasizing the problem-solving process with the patient was considered most useful. It was evident that the learning process was enhanced by meaningful discussion in the group. The members often referred to the lack of dynamic psychiatric teaching in medical school, and they came to appreciate the value of the interchange of views regarding emotional problems.

By lessening their own anxieties, some of these physicians were able to deal with chronic patients more comfortably, resulting in fewer patient visits. Less medication was required for chronic illnesses as the physicians became aware of the increasing influence of their relationship with the patient. Several physicians seemed to develop a better understanding of their own limitations; they felt they did not need to "cure" every patient. Several reported that they had come to enjoy this new approach, a type of personal gratification seldom experienced previously. Because of too few responses, we were unable to assess some of the more negative aspects that may have been withheld.

Much more data was elicited subsequently through casual meetings with the physician-student and through case consultations. Most of the physicians questioned referred to their increased confidence and skills in dealing with emotional problems. This was especially true with those who had remained with us for longer periods of time. They frequently referred to their improved ability to interview patients and also the value of video tape playback where nuances, both verbal and nonverbal, could be considered. This was a valuable learning instrument and perhaps the most effective way of providing an experimental learning process.[7]

Evaluation was actually an ongoing, integral part of the course itself. The members felt free to make suggestions for improving the curriculum, for improving case presentations, and for involving the physician in a more meaningful learning experience. Criticism of the psychiatrists included complaints of the local psychiatrists to report their findings in pragmatic terms, if at all. Atten-

dance was usually good, a valuable indicator as to the effectiveness of the program. Negative references oftentimes were made about the lack of sufficient content per se. Perhaps this reflects the fact that treatment caused more surfacing of anxiety in the patients in addition to the physicians' own initial anxiety about their lack of knowledge of psychiatric problems. These comments often were made by those who left the training program after the introductory course.

The physician-student's anxieties about his personal and professional problems were apt to surface more readily, but we carefully avoided pursuit of the physicians' personal histories. It seemed sufficient to share with the group and to gain mutual support. Devoting several hours a week to these seminars could well have served as an underlying method for dealing with their inner anxieties. We found this program to be an effective method for resolving some of these physicians' feelings of isolation in their practices. We suggest that such group experiences be made available periodically to the practicing physician.

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A Survey of Cancer Education: Physicians' and Dentists' Needs and Preferences

Susan E. Kogler Hill, Ph.D.
Mortimer B. Lipsett, M.D.

The Cancer Center, Inc. and The American Cancer Society sponsored a survey of over 7,000 physicians and dentists in Northeast Ohio to ascertain their cancer education needs and preferences. A questionnaire was designed to determine what (the content) health professionals needed to know regarding cancer and how (the method) they preferred to learn about it. Approximately 1,000 questionnaires were returned by date of analysis. In terms of content needs, physicians indicated a wide range of cancer types and sites in which they were in need of update, whereas, dentists specifically stated "detection" and "head and neck" cancer as their areas of greatest need. In terms of format, both physicians and dentists agreed that the ideal cancer education would occur in their local hospitals, before or after the busy part of the day, on a monthly basis, in the form of short courses or guest speakers. A discussion is included of the implications of this survey as to future cancer education programming.

ONCOLOGY IS ONE OF THE MOST rapidly growing, changing, and expanding fields in medicine today. Methods of treatment for various types of cancer are continually being developed or refined. Drug combinations for chemotherapy programs, methods for cancer detection, altered approaches to surgery, and radiotherapy are a few of the new areas. In addition, great strides are being made in basic cancer research in areas of immunology, virology, carcinogenesis, and cell biology. Such rapid growth and change, both in treatment and research, place great demands on the physician and the dentist. To provide good medical care for cancer patients, it is essential that the physician and the dentist be knowledgeable on recent developments.

Even though most medical professionals would agree that continuing education concerning cancer is crucial, the demands and pressures of their daily practices make it quite difficult to obtain this education. Typically, physicians and dentists receive many journals, pamphlets, and books. Conferences and meetings are also available for the professional to keep abreast of latest developments. In addition, audio-visual material, such as tapes and films, has been developed to meet the needs for continuing education in cancer.

Little research has been conducted, however, as to the educational needs and preferences of the medical community itself. Educational materials and programs are made available to physicians and dentists in a sincere, but often somewhat arbitrary, fashion.

In Northeast Ohio, The American Cancer Society and The Cancer Center Inc. share the goal of providing quality cancer educational programs for health professionals. These two institutions decided to address jointly the issue of professional education by sponsoring a research project to determine the needs and means of cancer education. A questionnaire survey was prepared and distributed to all physicians and dentists in the area to determine content needs and methodological preferences. The questionnaire was mailed to a total population of 7,127 physicians and dentists in the 12 counties of Northeastern Ohio.

The Questionnaire

Brevity and ease of completion were considered basic prerequisites for the questionnaire. It was designed so that a busy practitioner could simply respond to ten basic questions with check marks. Additional space was provided, however, to enable more detailed responses when necessary. To ensure prompt response, the questionnaire was preaddressed for return mail and merely needed to be folded, stapled, and returned. Estimated time to read, complete, and return-mail the questionnaire was five minutes.

Three important areas of information were selected as the base for the questions: (1) demographic data, (2) content needs in cancer education, and (3) educational format preference.

Certain demographic questions were asked because it was felt that some background factors might affect or influence cancer education needs and preferences. The

This research was jointly sponsored and funded by The Cancer Center, Inc. for Northeast Ohio and The American Cancer Society.

Dr. Hill, Cleveland, former Educational Director of The Cancer Center, Inc., is Assistant Professor, Department of Communication, Cleveland State University.

Dr. Lipsett, Bethesda, Maryland, Director of The Cancer Center, Inc. at the time this survey was conducted, is presently Director of the Clinical Center, National Institutes of Health.

Submitted January 10, 1977.

demographic questions were: specialty or area of practice, percentage of cancer patients treated, size and teaching status of hospital, and county of practice. Respondents were not asked to provide their names.

Content needs in cancer education were determined by two direct questions to ascertain the relative educational need for information about various types of cancer, and for information about other areas of cancer knowledge, ie, chemotherapy and detection. Subjects were asked to indicate the areas in which they needed upgrading. The purpose of the content questions was to determine which content areas in cancer education, if any, should be stressed in educational programming.

The third focus of the questionnaire was educational formats. Why would a medical professional attend one educational program over another; what educational methods had the professional used previously for up-to-date information; and what would the professional consider as the design of the "ideal" cancer education program. A five-part question was designed to ascertain the specific ingredients of the "ideal" program as to location, time of day, frequency, format, and methods. In effect, the professional was asked to design the educational structure that met his particular needs.

Mailing lists were obtained of all practicing physicians and dentists in Northeast Ohio. The questionnaire and cover letters of support from The Cancer Center, Inc. and The American Cancer Society were sent directly to the professional's office.

Results

Of the questionnaires mailed, 948 were returned at the time of this analysis. The overall rate of return was 13 percent for both physicians and dentists in all 12 counties. A more detailed breakdown of return is shown in the Table. Consistently, dentists responded more frequently than physicians. However, the low response from physicians in Cuyahoga County, Metropolitan Cleveland (7 percent), was attributable specifically to different mailing procedures, ie, the questionnaire was mailed with other educational materials rather than as a single item. It was concluded from this difference in rate of return that future educational surveys should be mailed separately to capture the physicians' attention and interest.

The data were analyzed by means of a computer program designed to show frequencies of response and relative comparisons between any and all questions. Through the use of this program, it was possible to analyze the data across any of the factors such as specialty, county, or teaching status of hospital. This enabled comparisons among various groups of responders.

The data obtained from the survey will be discussed in terms of the three general areas of information contained in the questionnaire: demographic data, content needs, and educational preferences. Only the most significant conclusions based on the computer evaluations will be cited herein with the responses of physicians and dentists discussed separately as educational programming for these groups is typically planned and organized separately.

Response to Questionnaire from Dentists and Physicians

Dentists	No. of Responses	%	Physicians	No. of Responses	%
Metro Cleveland	189	18	Metro Cleveland	196	7
Other Counties	218	21	Other Counties	345	17
	407	19		541	11

Demographic Data

Question: What is your area of practice?

The responses of the physicians to this question clearly showed no one specialty was representative. A large proportion (43 percent) of responding physicians checked either "internal medicine" or "family practice," indicating a large segment of physicians engaged in primary care. The dentists were not asked to indicate any subspecialties in their field.

Question: What percentage of patients whom you treat have some form of cancer?

A large majority of both dentists (95 percent) and physicians (74 percent) indicated that fewer than 10 percent of the patients seen in their daily practices had cancer. (The answer to this question points to the lack of motivation. If medical professionals only see cases of cancer occasionally, they will not be overly concerned or motivated to continue their education in this area.)

Question: What is the size of the hospital with which you are primarily affiliated? What is the teaching status of the hospital with which you are primarily affiliated?

The majority of dentists indicated they had no hospital affiliation. Overall, the responding physicians were located at medium (31 percent) and large (42 percent) hospitals. The exception to this rule was the physician population responding from the smaller, more rural counties.

The physicians' response to the question on teaching status was split, with 56 percent affirming teaching-hospital affiliation and 37 percent nonteaching affiliation. Predictably, the majority of the urban physicians indicated teaching affiliation, while the majority of the more rural physicians indicated nonteaching affiliation.

Cancer Content Needs

Question: Educational programs dealing with which of the following types of cancer would be most helpful to you?

Quite predictably, dentists responded (68 percent) that "head and neck" region was the site in which they were most interested. However, the physicians' responses were quite varied. Two sites (breast and gastrointestinal) each received an 18 percent response. No one anatomical

site received a large proportion of the response, indicating that choices varied as practice and specialty varied. The responses to this question support the idea that to fill the needs of the medical public, cancer educational programs must offer information on all of these sites.

Question: In what area(s) of cancer education do you feel the greatest need to be kept updated?

Variation in responses from physicians was evident in this question. Detection (25 percent) and chemotherapy (22 percent) were selected most frequently, but other topics, such as radiotherapy and surgery, had a fairly equal proportion of the responses. A majority of the dentists (52 percent) felt "detection" was the area in which they needed to be updated most.

Educational Format Preferences

Question: In deciding whether you will take advantage of an educational opportunity, what is/are your primary consideration(s)?

Physicians and dentists agreed that "relevance to everyday practice" (30 percent) was the most important factor followed by "Where it is — or location" (24 percent). The next most frequent response was "when it is" (19 percent). Factors such as cost, sponsor, or continuing education credit did not appear to influence the physician or dentist significantly.

Question: Please check those educational methods which have been particularly helpful to you in keeping up-to-date in cancer.

Physicians (30 percent) and dentists (33 percent) selected "journals and books" as the most helpful educational method in the past. For dentists, no other method had a sizable response. Physicians (23 percent) also indicated that "seminars" had been helpful. These two educational choices (journals and seminars) of physicians were consistent regardless of teaching status, hospital, or county of practice. Other educational options such as newspapers, pamphlets, local seminars, audio cassettes, dial access tapes, hospital educational television, or staff development, did not rate highly.

Question: If a cancer education program were designed specifically for you, how could it best be done?

Location: Physicians (52 percent) and dentists (40 percent) felt that their "local hospital" was the best place for cancer programs. Among the dentists in Cuyahoga County (Metropolitan Cleveland), a sizable proportion (30 percent) also felt that programs could take place in "regional metropolitan hospitals." The majority of physicians, regardless of county, felt that their local hospital, as opposed to regional metropolitan hospitals, vacation spots, or their offices, was the best place for cancer education.

Time of Day: Dentists (35 percent) preferred having their educational programs in the evening, and no other response choice received a sizable vote from them. Physicians were somewhat divided in their responses. Twenty-one percent agreed with dentists that the evening was best, and 22 percent felt early morning was best. Various combinations of morning and evening were found to predominate across all counties responding. In the more rural counties, physicians also selected weekends for cancer education. (The weekend response suggests that these physicians, because of their rural location, realize that they might have to travel greater distances to take advantage of an educational opportunity.)

It appears from the response rate of dentists and physicians, that both groups do not appreciate cancer education courses during the main part of their day. They appear to prefer education in the morning prior to their work day, or in the evening after it is over, or, if necessary, on weekends.

Frequency: Physicians and dentists were asked to indicate how often they would prefer some type of cancer education. Dentists were split evenly between "quarterly" and "semi-annually" (25 percent each). Dentists did not want frequent cancer programs, probably due to the fact that they see so few cases of cancer in their daily practice.

Overall, physicians (33 percent) selected "monthly" as the best frequency for cancer education. Another 22 percent of the physicians felt that it would be better if cancer education were conducted quarterly. Across counties, there was variation between preference for monthly and quarterly programming, however, variation was not related to county size or hospital teaching status.

Format: Dentists (34 percent) and physicians (30 percent) agreed that "short courses" was their preferred format for education. Another 23 percent of the physicians indicated that "guest speakers" would be the best format. Options such as case presentations, grand rounds, self-teaching devices, and conferences were not nearly so popular.

Methods: Physicians and dentists were similar in their selection of desirable educational methodologies. The methods receiving the highest votes were "personal observation" (28 percent), "audio-visuals" (22 percent), and "self-participation" (20 percent). It is interesting to note that these three methods together, observation, participation, and visual aids, describe the short course which was the preferred format selected by this group on the previous question. Methods such as educational television and reading materials were not selected as preferred education methods even though both physicians and dentists had stated earlier that journals and books had been most helpful in the past.

Summary of Results

A most interesting finding as a result of this survey was that the demographic factors did not influence response choices to any great extent. In general, regardless of county size, area of practice, or hospital size and status, responses were quite consistent. The consistency even carried across both groups of dentists and physicians.

The area of disagreement between physicians and dentists centered around the content questions. In the

question pertaining to physical site, dentists naturally felt "head and neck" education would be most helpful, whereas physicians were divided in their responses, reflecting the more general nature of their practices. Dentists were also more strongly in favor of programs focusing on "detection," reflecting the fact that they do not treat cancer. Physicians agreed that detection was the most important area for update, but they also selected other topics such as chemotherapy, radiotherapy, and surgery, showing their need for current information about cancer treatment and research.

The responses of physicians and dentists to these content questions showed the more selective educational needs of dentists focusing on the head and neck region, and detection of the disease. Responses of the physicians showed their diverse needs to be kept updated on all cancer sites as well as areas of knowledge.

Across all demographic factors, there was general consistency in responses to educational preferences. Factors affecting attendance at educational programs were "relevance to everyday practice," "where it is," and "when it is." Reading materials and seminars were the most helpful educational methods used in the past.

In selecting future educational programming, subjects agreed that the "local hospital" was the best location. The best time was either morning or evening, avoiding the busy time of day. Frequency for programming was monthly for physicians and quarterly for dentists. Both groups agreed that short courses and guest speakers were the best formats. The preferred methods for education were "personal observation," "audio-visuals," and "self-participation."

Discussion

The purpose of this survey was to determine physicians' and dentists' needs and preferences for cancer education in order to design and implement relevant and useful education programs. The responses to the questionnaire, while presenting only a limited percentage of the entire medical and dental population appear to be valid, due to the breadth and the consistency of the responses. All specialities, geographical areas, and teaching statuses are represented. The consistency of responses regardless of categories indicates that there is a general consensus of physicians' and dentists' educational needs in cancer.

The survey indicated that the type of programming for the physician population would not focus on any specific cancer topic, but would provide, however, an overview of the many areas of cancer knowledge. Special emphasis should be given to the more prevalent sites of cancer, ie, breast and gastrointestinal, as well as special attention to the topic of detection. For dentists, the cancer programs should concentrate on the head and neck region and on detection. An important factor to remember is that cancer programs should be "relevant to everyday practice." Every attempt should be made to translate current aspects of cancer treatment and research into a style or format that the practicing physician or dentist can relate to his or her own individual practice.

In addition to content areas, the questionnaire sought to determine preferences in methods for cancer education. Since journals and professional seminars have been useful education tools for most practitioners in the past, such methods should continue to be used. However, when asked to design future personalized programs for themselves, the physicians and dentists did not select more professional seminars or printed materials. Instead, the professionals described a flexible methodology with many educational variables and components. To varying degrees, educational programs could satisfy these expressed needs. However, one type of program in particular does seem to fit the expressed needs most completely. Such a program could be called traveling physicians or consulting teams. The program would consist of cancer specialists who would agree to travel individually or as a team to local, regional hospitals on a monthly or quarterly basis. Depending on the local physicians' needs, the program could be in the form of a short course or a lecture. The traveling physicians or dentists could prepare in advance a specific course on cancer, or they could merely respond to questions or discuss cases presented by staff. The local physicians could also select the hour of the program, either early morning or evening. This method would provide the aspects of personal observation with some self-participation and audio-visual materials. All of the ingredients of the "ideal" cancer program could be arranged within this method.

Effective cancer education is difficult due to the many time constraints of the medical professional. In addition, motivation is low for the physician or the dentist to learn about cancer. Health professionals might inadvertently choose to avoid learning about cancer because of its stigma of hopelessness, but even more importantly, the medical professionals stated that fewer than 10 percent of their patients had cancer. And yet, cancer is one of the leading causes of death. Almost all medical professionals, from the ophthalmologist to the dentist to the surgeon, come in contact with patients with some form of cancer.

Because of the scarcity of time and the low motivation, cancer education programs must be designed to fit the needs of each medical community if, in fact, these programs are to be effective. Surveying the medical population to determine their particular needs is an appropriate tool for educational planning, and the information therefrom enables the educational planner to design appropriate and motivating programs.

Specifically, the population under study in Northeast Ohio wants cancer education to reach out to them in their local hospitals at convenient times in challenging, involving, and flexible formats. This type of education is costly in terms of time and money; however, the most economical method might not be the most effective type of cancer education. Future evaluation of programs designed around needs should indicate their degree of effectiveness.

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THE OHIO STATE Medical Association Obituaries

BUELL L. ASHMORE, M.D., Chillicothe; University of Louisville School of Medicine, Louisville, Kentucky, 1916; age 88; died August 8; member OSMA and AMA.

ROBERT E. BALLARD, M.D., Wadsworth; Case Western Reserve University School of Medicine, 1931; age 72; died July 20; member OSMA and AMA.

STANLEY E. BROWN, M.D., Cleveland; Case Western Reserve University School of Medicine, 1925; age 77; died July 17; member OSMA and AMA.

ROY HERMAN CLUNK, M.D., Massillon; Ohio State University College of Medicine, 1928; age 76; member OSMA and AMA.

HATCHER A. DAY, M.D., Cleveland; Meharry Medical College, Nashville, Tennessee 1932; age 76; died July 26; member OSMA.

JOHN ALLEN FRASER, M.D., East Liverpool; University of Cincinnati College of Medicine, 1922; age 82; died August 4; member OSMA and AMA.

PATRICK J. FUSCO, M.D., Warren; St. Louis University School of Medicine, St. Louis, Missouri, 1925; age 77; died August 16; member OSMA and AMA.

MARCEL GREENBERG, M.D., Cleveland; Ohio State University College of Medicine, 1935; age 70; died August 4.

GRACE E. HASKINS, M.D., Cleveland; Case Western University School Medicine, 1931; age 79; died July 23.

LOUIS J. KARNOSH, M.D., Cleveland; Case Western University School of Medicine, 1920; age 85; died August 19; member OSMA and AMA.

BAYARD M. KELLER, M.D., Chardon; Ohio State University College of Medicine, 1939; age 64; died August 13; member OSMA and AMA.

JOSEPH D. MANNINO, M.D., Cleveland; University of Cincinnati College of Medicine, 1918; age 81; died July 14; member OSMA and AMA.

WILLIAM M. McLIN, M.D., Indianapolis, Indiana; Indiana University School of Medicine, Indianapolis, Indiana, 1931; age 70; died August 3; member OSMA and AMA.

SWEN D. NIELSEN, M.D., Vermilion; Case Western Reserve University School of Medicine, 1940; age 74; died July 31; member OSMA and AMA.

DALE P. OSBORN, M.D., Cincinnati; Northwestern University Medical School, Chicago, Illinois, 1922; age 82; died July 31; member OSMA and AMA.

RALPH E. RASOR, M.D., Findlay; Ohio State University College of Medicine, 1931; age 73; died July 19.

GEORGE A. SUDIMACK, M.D., Warren; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1942; age 60; died August 9; member OSMA and AMA.



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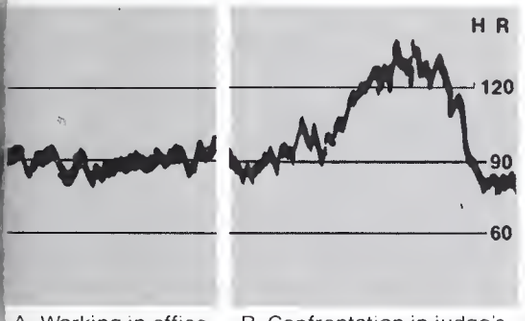
"Our sex life is nil..." A problem of the first magnitude to many post infarct patients and their mates.. patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

Sex and the heart patient:

A film every doctor should see.

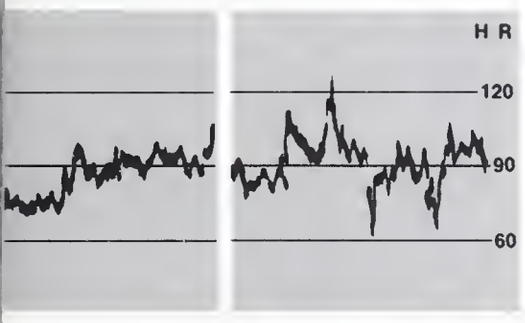
The energy cost of sex to the heart is relatively modest.
Over 80% of post-coronary patients can ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extra-marital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



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B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)

D. Peaks at orgasm (120 beats/min)



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THE OHIO STATE Medical Association News

OSMA Forms Education And Research Foundation

Physicians concerned with the promotion of good health for the people of Ohio can now make contributions to the newly formed Ohio Medical Education and Research Foundation (OMERF).

The Foundation, which will operate exclusively for charitable, educational, and scientific purposes, will be funded through tax deductible contributions and bequests from physicians, their families, and other persons concerned with promoting social and general welfare through medical and health research and education.

William M. Wells, M.D., OSMA President and an OMERF trustee, said the Foundation will also serve to formulate and maintain educational programs designed to improve public knowledge in matters of personal, family, and public health. Continuing medical education programs for physicians and financial assistance to medical schools and medical students will also be fostered through the Foundation.

Dr. Wells emphasized that the Foundation will not participate in attempts to influence legislation nor become involved in any political activities.

Additional priorities of the Foundation include the study and formulation of improved methods of medical and health care delivery and dissemination of the results of scientific and medical research to the general public.

The Foundation was created by official action of the OSMA Council earlier this year. In addition to Dr. Wells, the initial trustees for the non-profit, tax-exempt Foundation include George N. Bates, M.D., Toledo, OSMA Immediate Past-President and Robert G. Thomas, M.D., Elyria, OSMA Secretary-Treasurer.

Physicians wishing to make a tax-deductible contribution to OMERF should contact Hart F. Page, OSMA Executive Director, 600 South High Street, Columbus, Ohio 43215, telephone: 614/228-6971.

Montgomery County Discontinues Medical Television Program

The Montgomery County Medical Society and the Miami Valley Broadcasting Corporation, WHIO-TV, were honored recently on the occasion of the last taping of their "Medical Hotline Show." On the air for five years, the half-hour, phone-in program has informed the public of different aspects of the medical profession. Viewers were given the opportunity to speak directly with program guests who discussed topics ranging from childhood diseases to coping with stress. Medical Society members Alfred Hicks, M.D., and Stanley Sturges, M.D., acted as coordinators of the program, working with moderator/producer Bob Sweeney and co-producer Nancy Heath.

Ohio Departments Unite In Immunization Drive

Two departments of the State of Ohio held a joint news conference in August marking a new tactic in the battle to have all Ohio children properly immunized. State Superintendent of Public Instruction, Franklin Walter, Ph.D., and State Director of Health, John Ackerman, M.D., jointly warned parents of school-aged children to make certain those children have completed childhood immunizations before the start of the new school year.

Ohio law requires each child to have the immunizations before being admitted to school. Under the law, local boards of education have the power and the duty to refuse admission to any child who has not completed the full immunization series.

Dr. Ackerman noted that approximately 8 percent

(continued on page 718)

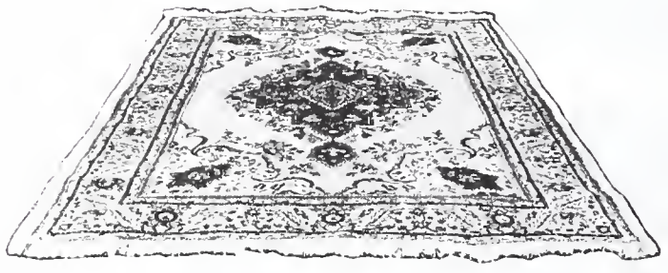
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59 Postgraduate Courses—This large selection of Category 1 courses allows you to concentrate on those areas in which you want to update and upgrade your medical knowledge and skills (See overleaf.)

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See overleaf for complete listing of postgraduate courses

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Scientific Program

AMA 31st Winter Scientific Meeting

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Advances in Rheumatoid and Collagenous Vascular Disease: Diagnosis and Therapy
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Ophthalmology for the Nonophthalmologist
Medical and Surgical Management of Skin Cancer
Basic Life Support—CPR
Fluid and Electrolyte Balance
Hypoglycemia: Diagnosis and Management
Diagnosis and Treatment of Fractures of the Lower Extremities
Medical and Surgical Management of Coronary Vascular Disease
Noninvasive Diagnostic Radiological Techniques
Dermatology for the Nondermatologist
Sports Injuries
Biofeedback and Other Techniques
Clinical Aspects of Immunology
Diabetes: Diagnosis and Management
Psychotropic Drugs: Uses and Abuses
Unsticky Platelets—Loose Clots
Infectious Diseases in Children
Office Gynecology
Drugs: Actions, Reactions, and Interactions
Care of the Critically Ill: Medical and Surgical Management
Office Endocrinology
Newer Clinical Approaches to the Sexually Transmitted Diseases
Diagnosis and Treatment of Fractures, Dislocations, and Epiphyseal Injuries in Children
Advanced Life Support—Cardiopulmonary Resuscitation (CPR)
Medical and Emotional Problems of Aging
Hypercalcemia: Diagnosis and Management
Evaluation and Management of the Jaundiced Patient
Pediatric Feeding and Nutritional Problems
Office Neurology
Psychiatry for the Nonpsychiatrist
Indications for Total Joint Replacement
Management of Acute and Chronic Pulmonary Problems
Evaluation and Management of Hyperlipidemias
Emergency Medicine for 1978
Pediatric Allergy and Immunology
Management of Renal Failure
Management of Hepatic Problems
Diagnosis and Treatment of Fractures of the Upper Extremities
The Integration of Adjuvant Modalities in the Treatment of Cancer
Nephrolithiasis: Diagnosis and Management
Evaluation and Management of Arrhythmias
Current Antibiotic Uses and Abuses
Evaluation and Management of Common GI Problems
Office Orthopedics
Evaluation and Management of Common Urinary Tract Problems
Use and Consequences of Steroids
Exercise Testing and Physical Fitness Proficiency
Advances in Antibiotics and Other Antimicrobials
Evaluation and Management of Seizure Disorders
Evaluation and Management of GI Bleeding
Alcohol and Drug Abuse
Advanced Electrocardiography

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THE OHIO STATE Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

October 1977

INTERNATIONAL SYMPOSIUM ON SODIUM VALPROATE: October 24, Holiday Inn Campus, Columbus; sponsor: Children's Hospital and OSU College of Medicine; 6 credit hours; fee: $25, $10 banquet fee- evening of 24th; contact: Department of Education, Children's Hospital, 700 Children's Drive, Columbus 43215, phone: 614/224-6116.

November 1977

HEPATOBILIARY DISEASE: November 3; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, General Surgery, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

RHINITIS: November 5, 8:30 AM; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip Hardymon, Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

COMPREHENSIVE MANAGEMENT OF SEIZURE DISORDER: November 9; Cleveland Clinic Foundation; 6 credit hours; fee: $50, 25 residents; contact: A. David Rothner, M.D., Section, Child Neurology, Cleveland Clinic, Cleveland 44106, of CME, The Cleveland Clinic Educational Foundation, 9500 phone: 216/444-5514.

DERMATOLOGY: November 9; University of Cincinnati College of Medicine, Cincinnati; 5 credit hours; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone 513/872-5486.

DETECTION AND TREATMENT OF EARLY BREAST CANCER: November 9; Grant Hospital, Columbus; 4 credit hours; contact: Malcolm S. Hayden, Director of Development, Grant Hospital, 309 East State Street, Columbus 43215, phone: 614/461-3232.

NEUROLOGY— RECENT ADVANCES: November 9; Eugene W. Kettering Center for Continuing Education, Dayton; sponsor: Wright State University School of Medicine; cosponsor: Miami Valley Hospital; 4 credit hours; fee: $20; contact: Arlene Poster, Program Coordinator, Wright State University, Dept. PMCE, P O. Box 927, Dayton 45401, phone: 513/372-7140.

FAMILY PRACTICE SEMINAR ON RECENT ADVANCES IN PRIMARY CARE: November 9-10; Hospitality Inn, Middleburg Heights; sponsor: Westshore Foundation for Medical Education; cosponsor: Fairview General Hospital and Lakewood Hospital; 9 credit hours; fee: $50; contact: The Family Practice Center, 18099 Lorain Avenue, Cleveland 44111, phone: 216/252-7071.

BIOFEEDBACK— TREATMENT OF HEADACHES AND OTHER STRESS RELATED DISORDERS: November 11; Cleveland Clinic Foundation, Cleveland; 6 credit hours; fee: $50, $25 students; contact: Penn G. Skillern, M.D., Director Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

HEMATOPATHOLOGY: November 11-12; University of Cincinnati College of Medicine, 231 Bethesda Avenue, Cincinnati; sponsor: CONMED; 10 credit hours; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone 513/872-5486.

HYPERTENSION TODAY: EVALUATION AND TREATMENT: November 12; Holiday Inn at Toledo-Perrysburg, Perrysburg; sponsor: Medical College of Ohio; 6 credit hours; fee: $15; contact: Howard S. Madigan, M.D., Associate Dean for Continuing Education, Medical College of Ohio, C.S. 10008, Toledo 43699, phone: 419/381-4237.

FEVER OF UNKNOWN ORIGIN: November 15, 7:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller or Ms. Karen Saslaw, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

RECURRENT URINARY TRACT INFECTION: November 15, 8:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller or Ms. Karen Saslaw, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

LABORATORY MEDICINE: November 16; University of Cincinnati College of Medicine, Cincinnati; 5 credit hours; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

CLINICAL GASTROENTEROLOGY: November 16-17; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CHOLECYSTITIS AND CHOLEDOCHOLITHIASIS: November 17; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, General Surgery, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

CLINICAL EXPERIENCES WITH CARCINOEMBRYONIC ANTIGEN IN CARCINOMA OF THE COLON: November 19; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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THE OHIO STATE Medical Association Medical School Highlights

Northeastern Ohio Universities College of Medicine

Robert A. Liebelt, Ph.D., M.D., Dean

Northeastern Ohio Universities College of Medicine (NEOUCOM) received provisional accreditation on June 30, 1977 from the Liaison Committee on Medical Education. This committee, composed of representatives of the American Medical Association and the Association of American Medical Colleges, endorsed the medical portion (Phase II) of the six-year, combined BS/MD degree program.

This significant step in the accreditation process permitted 48 students to begin Phase II in September 1977 at the newly constructed basic medical sciences facility in Rootstown. Phase II begins with Year 3, or the basic medical sciences portion of the curriculum.

The provisional accreditation of the College of Medicine is of even greater significance when viewed from the long-range perspective because it is a major step toward attaining the status of an "accredited medical school." This is scheduled for 1981, just prior to the graduation of the first class of physicians.

Thus, it is with pride but more importantly as a tribute to the untold efforts of many people in the state government, the communities, the hospitals, and the universities that we welcome this opportunity to describe "our College of Medicine."

Historical Background

The establishment of NEOUCOM was preceded by independent efforts of The University of Akron, Kent State University, and Youngstown State University to determine the feasibility of developing medical schools on their respective campuses in the early 1960s. Recognizing the impracticality of constructing three new medical schools in northeast Ohio, these efforts became a joint activity of the three universities, who relied on community leaders and particularly practicing physicians for the necessary leadership.

This cooperative effort culminated on June 14, 1972 when Governor John J. Gilligan signed Am. Sub. SB 457, which provided $50,000 to develop "a consortium of state universities in northeast Ohio for preparation of detailed plans for medical education based insofar as practical upon facilities of existing universities in each area and community facilities."

This legislation was followed by the formation of the Medical Education Development Center, Inc. (MEDCO), to "develop a plan for expanding medical education opportunities in northeastern Ohio including the establishment of a medical school." Having engaged a group of distinguished educational consultants under the direction of Stanley W. Olson, M.D., MEDCO worked extensively with four local committees composed of physicians, hospital administrators and trustees, university faculty, and public members. *The MEDCO Plan for Medical Education-1973* was delivered to the Governor, the Ohio General Assembly, and the Ohio Board of Regents on December 29, 1972.

A bill to establish the Northeastern Ohio Universities College of Medicine was introduced in the 110th General Assembly, where it enjoyed strong support. Governor Gilligan signed SB 72 on August 24, 1973; and the College of Medicine became a legally established institution of higher education in Ohio on November 23, 1973. Dr. Olson was appointed the first provost (president) of the College of Medicine.

Almost simultaneously, these events were paralleled by the development of another new medical school at Wright State University, providing Ohio with six medical schools. The unique regional distribution of medical schools in Ohio, to which was recently added a seventh at Ohio University, represents an almost unprecedented network that assures that practicing physicians throughout the state now have relatively easy access to the varied resources of a medical school, particularly in the area of continuing medical education.

Objectives of the College of Medicine

The chief goal of the medical education plan of NEOUCOM is to improve the quality and availability of health care for the more than 2½ million people residing in northeast Ohio. The leadership and assistance provided by the College of Medicine will serve to coordinate the academic resources of the three universities, the clinical teaching capabilities existing in major community hospitals, and the educational involvement and commitment of a significant number of highly qualified physicians of the region. In addition, the College of Medicine is developing a basic medical sciences faculty, housed in wholly new facilities in Rootstown, which will complement and strengthen existing university and hospital resources. The principle of sharing rather than duplicating available facilities will significantly reduce the required capital costs of medical education and will also provide a setting in which the successful attainment of the following specific objectives can be anticipated:

1. To develop an integrated medical curriculum so that the articulation of the several stages of a medical education provide a realistic continuum in the educational development of a physician.
2. To provide an opportunity for medical students to participate in the continuing medical care of patients with the expectation that this experience will influence a substantial number of graduates to become primary care physicians.
3. To afford the student the opportunity of completing an integrated curriculum of 24 academic quarters in a period of six calendar years, including summer sessions, culminating with the receipt of both the BS degree from one of the consortium universities and the MD degree from the College of Medicine. (It should be noted that 24 quarters is considered a minimum period of time.) This six-year pattern is also aimed at encouraging students to remain in northeastern Ohio for their residency training.
4. To assist the hospitals associated with the medical school to develop an appropriate teaching environment for undergrad-

uate medical education through the recruitment of full-time faculty, provision of funds for additional teaching facilities, and further development of residency programs. All of these will, in turn, improve patient care.

5. To develop a strong, basic medical sciences faculty, who can provide expertise in teaching and research, not only as part of the undergraduate medical curriculum but also for residency programs and continuing medical education of practicing physicians.

6. To facilitate the development of doctoral programs in the biomedical sciences at the three consortium universities.

Implementation of the Plan

One of the major strengths of the College of Medicine has evolved from the MEDCO Plan; this document had been made available for all to read prior to the legislative creation of the College of Medicine. In addition, implementation of the plan has proceeded with no significant deviations. Accordingly, understanding and credibility among the multiple participants in the two major consortia (the universities and the hospitals) have developed.

Facilities

The College of Medicine was assured a strong academic base due to the physical resources of the three consortium universities. Similarly, the clinical base was provided by the relatively large community hospitals in the Akron, Youngstown, and Canton areas plus Robinson Memorial Hospital in Ravenna. Upon receiving $13 million from the State of Ohio, the missing ingredient— a facility to house the administration of the College of Medicine as well as the needed teaching and research space for the basic medical sciences faculty— was designed and constructed in Rootstown, a geographically convenient site with respect to the three communities.

While the construction at Rootstown was underway, $11.9 million became available from the State of Ohio to build ambulatory care teaching facilities at the several associated hospitals to meet the teaching needs of the curriculum. Plans for this construction have been developed and coordinated among the several hospitals.

In contrast to the usual stated amount of $100-$150 million needed to start a new medical school, of which a large portion is used for the construction of a university teaching hospital, the State of Ohio has invested approximately $25 million in capital expenditures to date for the College of Medicine.

Faculty

Faculty responsible for teaching the integrated combined BS/MD degree program originate from these sources: (1) university faculty members of the three consortium universities, (2) basic medical sciences faculty, and (3) clinical faculty. The university faculty members are responsible for development of the baccalaureate curriculum, especially the basic sciences, of the combined degree program. Individuals selected for basic medical science faculty positions have had teaching experience in medical schools and have a biomedical orientation in the sciences. As its major responsibility, the basic medical sciences faculty will organize the third year of the curriculum as well as contribute to years four, five, and six in conjunction with the clinical faculty.

Since the College of Medicine will not have a university hospital but will use the resources and facilities of the eight associated hospitals, two major groups of clinical faculty were identified: (1) the full-time, hospital-based physician and (2) the physician in private practice who is on the staff of a given hospital. The organizational approach of the clinical faculty is one that reflects a modification of the procedure employed by Brown University and Harvard University Schools of Medicine. The key structural component is called the "Council of Chiefs."

Each specialty has a council of chiefs composed of the chairman or academic director of the department in each of the eight associated hospitals. To date, councils of internal medicine, surgery, pediatrics, obstetrics/gynecology, family practice, radiology, pathology, orthopedics, and psychiatry have been organized. From an administrative point of view, two additional councils have also been formed: coordinators of graduate medical education and hospital executive officers. These 11 councils represent the core of the clinical faculty organization.

At the present time, the councils are focusing on two major areas. One is the development and strengthening of on-going residency programs and the planning for new residency programs. The second area is the development of the curriculum for the clinical core clerkships as well as input into the planning of the curriculum for the other years of the Phase II curriculum.

Each council is working closely with the Office of Medical Education Research and Curriculum Development to develop teaching objectives and techniques for evaluation of the teaching program. This office plans, implements, coordinates, and evaluates the components of the six-year, BS/MD curriculum. In addition, this office operates three service divisions for the College of Medicine: (1) Basic Medical Sciences Library and the NEOUCOM Library Network, (2) Audiovisual Sciences and Health Communications Division, and (3) Biomedical Computer Services Division.

The uniqueness of the plan for library services deserves special note. The regional organization of the College of Medicine requires that the library, likewise, be organized on a regional basis. In the past seven years, the Cleveland Health Sciences Library (CHSL) has operated a network arrangement (NEONET) with numerous hospitals in northeastern Ohio. It is in conjunction with this network that the College of Medicine is developing its library resources. The NEOUCOM Library Network will consist of the Cleveland Health Sciences Library; The University of Akron, Kent State University, and Youngstown State University libraries; a basic medical sciences library (Rootstown); and the libraries of the associated hospitals in the consortium. Each node of the network will have access to the holdings of the other component members by way of electronic communication systems as well as a courier transportation service to facilitate the actual movement of books and instructional materials. Eventually, this transportation system will be expanded to move people involved in teaching, research, and service in NEOUCOM facilities.

(continued on page 716)



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Curriculum

The proposed six-year, integrated, combined BS/MD degree program originated in the concept that the usual components of a physician's education and training (high school, college, medical school, internship, and residency training) should be articulated into a continuum educational experience. The fusion of high school and college at one end of the spectrum, and residency, internship, and senior year of medical school at the other end has already taken place. The gap remains between college and medical school.

Presently in the United States, there are approximately ten medical schools that are attempting to close this gap by developing six-year programs (two years premedical and four years medical school). Our proposed curriculum follows this pattern with several significant differences.

Phase I, life sciences curriculum, is nine academic quarters in duration and is taught principally on the campuses of the three consortium universities. Courses and their content were developed in conjunction with the College of Medicine, anticipating the level of preparation desired before the student enters Phase II.

Phase II consists of 15 academic quarters with four devoted to the basic medical sciences, eight to the clinical sciences, and three to the humanities and social and behavioral sciences. The latter quarters require that the students return to their respective university campuses for one quarter during each of the three clinical years to take courses mainly in the humanities. This timing is unusual as these courses are normally undertaken in premedical education.

In effect, the student spends a total of 24 academic quarters, equivalent to the more traditional four years undergraduate and four years medical curriculum, except that by attending summer sessions, the student can complete the curriculum in six years. He receives the BS degree from one of the three universities and the MD degree from the College of Medicine. Provisions are made so that a student can extend the time period under appropriate circumstances.

One rather important and unique feature of the curriculum is found in Year 4. This year (nine months) will be spent in one or more of the community hospitals except for one morning each week when the student returns to Rootstown for a basic science correlation course. While in the hospital, the majority of time will be spent in the ambulatory care teaching facilities under the aegis of the Council of Family Practice. It is hoped that this early exposure to ambulatory care experiences will assist in achieving NEOUCOM's projected goal of approximately 50 percent of graduates entering the primary care sector of medical practice. In addition, it is hoped that all students who complete this curriculum will have gained an appreciation and understanding of the importance and role of the community-oriented physician.

Students

At first glance, development of an admissions policy that included identification of students who were entering the first year of undergraduate premedical studies, the involvement of three universities, and the accreditation status of the College of Medicine seemed a complex and impossible task. Through cooperation by all involved, an admissions policy was developed that reflected the need for the continuum nature of the combined degree program and, at the same time, emphasized the restraints placed upon identifying students as medical students prior to the establishment of the accreditation of the College of Medicine. This admissions process is divided into two distinct phases.

Phase I is the admission process to the two-year premedical portion of the curriculum; and Phase II is admission to the four-year, medical-school portion of the curriculum. To retain the continuum spirit of the curriculum, several committees were organized: (1) Special Joint Admissions Committee composed of five university faculty members and five representatives of the College of Medicine (practicing physicians) on each campus; (2) Academic Review and Promotions Committee made up of three university faculty members from each campus and nine College of Medicine faculty members; and (3) College of Medicine Admissions Committee composed of nine university faculty and nine College of Medicine faculty members.

The admissions policy holds that those students admitted into Phase I of the program are not assured admission to Phase II of the program unless they perform satisfactorily during the first two years of the program. Such performance is to be evaluated by the Phase I Academic Review and Promotions Committee. In turn, these students must also be approved for entrance into Phase II by the College of Medicine Admissions Committee. Phase I students are university students and not College of Medicine students.

Because of the rather strenuous curriculum proposed for Phase I, it is anticipated that attrition may occur. All three universities agreed that any attrition occurring during Phase I would not be filled by additional students. The vacancies will remain until the beginning of Phase II. At that time, the number of students needed to return the class to its total number would be selected from applicants with a traditional premedical and/or baccalaureate educational experience at any college or university with preference being shown toward Ohio residents. Thus, there are two entry points into the NEOUCOM program: selection for Phase I as a high school senior, or completion of premedical educational requirements and direct entrance into Phase II.

Development of the College of Medicine has now reached the Phase II entry stage for the charter class. Forty-eight students began basic medical sciences studies on September 12, 1977 on the Rootstown campus. The continued strong support of many organizations and people will assure the graduation of this first class in 1981. This and many classes thereafter will be well-educated and well-trained physicians who will be a source of pride not only to the people of Northeast Ohio, but to all citizens of the State of Ohio.

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News *(continued from page 708)*

of the more than two million children in Ohio are not immunized adequately. The measles epidemics of last winter have made all health officials aware of the seriousness of improper immunization. He said that Ohio can expect more measles epidemics until "catch-up" immunization campaigns are successful, and he reminded parents that one of every thousand measles cases develops serious complications which can kill or cripple a child.

Parents can have their children immunized free or at low cost through their local Department of Health clinics if they do not have a personal physician.

HEW Announces Restrictions on Federal Payments for Abortions

The Department of Health, Education, and Welfare (HEW) has announced that it "will provide Federal financial participation in the cost of abortions only where the attending physician, on the basis of his or her professional judgment, has certified that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term."

This announcement is in compliance with Section 209 of Public Law 94-439, the Labor-HEW Appropriation Act of 1977. Popularly known as the Hyde Amendment, this section provides that: "None of the funds contained in this act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term." In October 1976, a Federal District Court issued an order enjoining HEW from enforcing the Hyde Amendment. That injection has now been dissolved.

The Amendment does not bar funding for certain medical procedures. The Conference Committee Report interpreting the Hyde Amendment states: "Nor is it the intent of the Conferees to prohibit medical procedures necessary for the termination of an ectopic pregnancy or for the treatment of rape or incest victims; nor is it intended to prohibit the use of drugs or devices to prevent implantation of the fertilized ovum." Treatment for rape or incest victims is, however, limited for these purposes to prompt treatment before the fact of pregnancy is established. As in all cases, federal funds for abortions for rape or incest victims will be available where the physician has certified that the life of the mother would be endangered if the fetus were carried to term.

Physicians to Advertise in N.Y.

The New York State Board of Regents has authorized physicians, dentists, and other professionals in New York to advertise both their services and prices in newspapers and magazines. Advertising of services, but

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not quotation of prices also will be allowed on broadcast media. The action followed the United States Supreme Court decision of June 1977 that banned restrictions on advertising by lawyers.

National Cancer Institute Offers Thyroid Cancer Publications

The National Cancer Institute (NCI) has announced a program to inform the professional community and the general public about irradiation-related thyroid cancer. The goals of the education program are: (1) to brief physicians on how to examine, diagnose, and treat irradiation-related thyroid tumors; and (2) to urge the special population that is at increased risk of developing thyroid cancer to be examined by a physician.

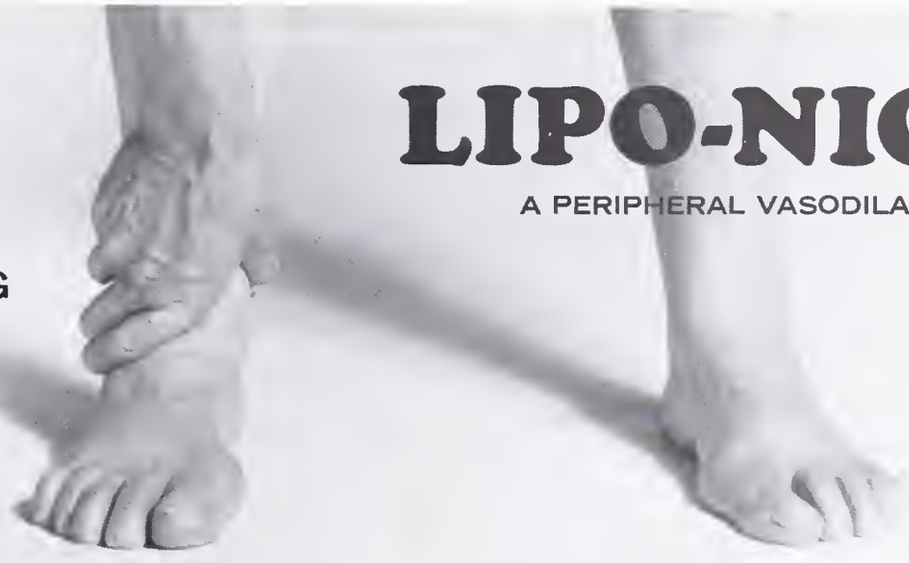
Two publications are being distributed by the NCI as the initial step in making information available to professionals and the general public: "Irradiation-Related Thyroid Cancer," designed for physicians; and "Did You, as a Child or a Young Adult, Have X-Ray Treatments Involving Your Head or Neck?" designed for the general public. These publications may be ordered without charge from the Office of Cancer Communications, Department G, National Cancer Institute, National Institutes of Health, Bethesda, Maryland 20014.

Medical Board Activity

The following is a list of activities and actions undertaken from July 1, 1977 to July 31, 1977 by the Ohio State Medical Board.

LICENSURE ACTIVITY		
American and Canadian Graduates		
Licensed by Endorsement	M.D.	156
	D.O.	48
Licensed by Examination	M.D.	0
	D.O.	0
Foreign Medical School Graduates		
Licensed by Endorsement		47
Licensed by Examination		0
Sept. 1972 FLEX Board Policy Licenses		1
Endorsements to Other States	M.D.	45
	D.O.	0
ENFORCEMENT ACTIVITY		
Formal Citations Issued		0
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act		10
Voluntary Surrenders of Medical Certificates		1
Arrests for Alleged Illegal Practice of Medicine		0
Formal Hearings on Alleged Violations of the Medical Practice Act		1

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Nicotinic Acid .....250 mg.
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Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Colleagues in the News

County Society Officers Change

(See April 1977 Journal for all other societies.)

ALLEN: Thomas R. Leech, M.D., president, 1108 National Bank Bldg., Lima 45801; William T. Collins, M.D., secretary-treasurer, Lima Memorial Hospital, Lima 45804; Will Wolf, executive secretary, Box 1647, Lima 45802, phone: 419/228-1105. Third Tuesday, September through May. Third District.

BUTLER: James I. Scott, Jr., M.D., president, 1380 N.W. Washington Blvd., Hamilton 45013; John M. Evans, M.D., secretary-treasurer, 685 Tari Ln., Hamilton 45013; Mrs. Joan William, executive secretary, 111 Buckeye St., Hamilton 45011, phone 513/893-1410. Fourth Wednesday, October-May except December. First District.

CUYAHOGA: Edward G. Kilroy, M.D., president, 20800 Westgate Ct., Cleveland 44126; Richard J. Nowak, M.D., secretary-treasurer, 20620 N. Park Blvd., Cleveland 44118; Robert A. Lang, Ph.D., executive director, 10525 Carnegie Avenue, Cleveland 44106, phone 216/231-3500. Fifth District.

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HAMILTON: Carl G. Thompson, M.D., president, 938 Hempstead Dr., Cincinnati 45231; Robert P. Hummel, M.D., secretary, Eden and Bethesda Aves., Cincinnati 45219; William J. Galligan, executive secretary, 320 Broadway, Cincinnati 45202, phone: 513/721-2345. Second Tuesday except August. First District.

KNOX: Alan K. Fairchild, M.D., president, 4 N. Gay St., Mt. Vernon, 43050; James H. Risko, M.D., secretary-treasurer, 307 Vernedale Dr., Mt. Vernon 43050. First Wednesday. Tenth District.

Sports Medicine Awards Presented

The Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and the Ohio High School Athletic Association, in cooperation with the Ohio High School Football Coaches Association, has presented the Ohio Sports Medicine Awards for 1977. These awards were presented in August to ten Ohio team physicians.

ROBERT J. MURPHY, M.D., a founder of the Joint Advisory Committee on Sports Medicine, received the Special Award for Outstanding Achievement in Sports Medicine. Dr. Murphy served as the first chairman of the Committee (1961-1966) and has also spearheaded statewide sports medicine institutes over the years (1960-1976). One of the nation's leading medical authorities on the prevention of heat illness among athletes, Dr. Murphy is head team physician at The Ohio State University. He is in the private practice of internal medicine in Columbus.

Each of the recipients of the Outstanding Team Physician Awards has served as a team physician for more than 20 years. Physicians honored for their service to the youth of Ohio are:

WADE A. BACON, M.D., team physician for David Anderson High School, Lisbon;
WALTER K. CHESS, M.D., team physician for John Glenn High School, New Concord;
JAMES M. FRASER, M.D., team physician for Perrysburg High School, Perrysburg;
NED B. HEIN, M.D., team physician for Start, Scott, DeVilbiss, and Central High Schools, Toledo;
JOHN C. KELLEHER, M.D., team physician for St. Francis DeSales High School, Toledo;
PETER LANCIONE, M.D., team physician for Bellaire High School, Bellaire;
JANIS LAUVA, M.D., team physician for Wellsville High School, Wellsville;
JAMES F. MASON, M.D., team physician for Upper Arlington High School, Columbus; and
GUS SHAHEEN, M.D., team physician for Lehman and McKinley High Schools, Canton.

* * *

C. ALEX ALEXANDER, M.D., Dayton, has been chosen President-Elect of the American College of International Physicians. Chief-of-Staff of the Veterans Administration Center in Dayton, Dr. Alexander is a Fellow of the American College of Preventive Medicine, the American Public Health Association, and the American College of International Physicians. He is also Clinical Professor of Community Medicine at Wright State University School of Medicine.

RALPH J. ALFIDE, M.D., Cleveland, is the president of the newly formed Society of Computed Body Tomography. The Society, which was organized in January 1977, is composed of diagnostic radiologists who are active in the clinical utilization of computed tomography.

"Colleagues in the News" is sponsored by

Blue Shield
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(PAID ADVERTISEMENT)

Five Cleveland Clinic medical staff members have been elected to the board of trustees of the Cleveland Clinic Foundation. The new board members are:

ANTONIO R. ANTUNEZ, M.D., Chagrin Falls, Head of Radiation Therapy and Nuclear Medicine;

CALDWELL B. ESSELSTYN, JR., M.D., Pepper Pike, a general surgeon;

WILLIAM C. SHELDON, M.D., Pepper Pike, Head of the Department of Cardiology;

BRUCE H. STEWART, M.D., Shaker Heights, a urologist; and

WILLIAM S. KISER, M.D., Shaker Heights, Chairman of the Board of Governors of the Clinic. Dr. Kiser, a urologist, was also elected Executive Vice-President of the Board of Trustees.

BERTIE B. BURROWES, M.D., Youngstown, was the guest of honor at the testimonial dinner given by his medical colleagues and community residents. The event marked 36 years of community and medical service provided by Dr. Burrowes. Dr. Burrowes is a member of the Clinical Staff of the Youngstown Hospital Association.

The American College of Physicians has announced that the following Ohio physicians have been admitted to Fellowship in the College. The honorees earned the membership rank through evidence of scientific accomplishments and by acceptance as leaders in their specialty as determined by fellow practitioners. Listed by city, the new Fellows are:

Akron: **DONALD F. EIPPER, M.D.; LEO LUTWAK, M.D.**; and **FRANK P. URSO, M.D.**
Beachwood: **LAWRENCE W. WHITE, M.D.**
Cincinnati: **JAMES W. AGNA, M.D.**, and **CAROL A. KAUFFMAN, M.D.**
Cleveland: **GRANT L. HELLER, M.D.; ROBERT S. KUNKEL, JR., M.D.; MAHMOOD MOINUDDIN, M.D.**; and **KENNETH S. WARREN, M.D.**
Columbus: **GEORGE E. BELL, M.D.; JAMES A. NEIDHART, M.D.**; and **STEPHEN F. SCHAAL, M.D.**
Dayton: **SATYENDRA C. GUPTA, M.D.**, and **RICHARD A. SERBIN, M.D.**
Hamilton: **KENNETH L. WEHR, M.D.**
Middletown: **PETER A. AMMENTORP, M.D.**

KENNETH A. FREDERICK, M.D., Cincinnati, is the 27th president of the Ohio Academy of Family Physicians. A specialist in the care of the aging, Dr. Frederick is Associate Director of the Family Practice Center of the University of Cincinnati Medical Center and Associate Professor in the College of Medicine's Department of Family Medicine. He is also medical director of Twin Towers, the Methodist Home located in Cincinnati.

JOSEPH F. LYDON, M.D., has been elected president of the Cleveland Surgical Society for the 1977-1978 year. Other officers include **JAMES L. BERK, M.D.**, president-elect; **MADHIRA D. RAM, M.D.**, secretary-treasurer; and councilors **JAMES C. JONES, M.D.**, and **ALBERT M. ZIPPERT, M.D.** Immediate past-president of the Society is **ROBERT M. ZOLLINGER, JR., M.D.**

JOHN C. MELNICK, M.D., Youngstown, has achieved the status of Diplomate of the American Board of Nuclear Medicine. Dr. Melnick, who is also certified by the American Board of Radiology, is Director of the Department of Nuclear Medicine of the Youngstown Hospital Association. A past president of the Mahoning County Medical Society and a delegate to the OSMA House of Delegates, he is also noted for his penchant for history. Dr. Melnick has authored two books, *History of Medicine in Youngstown, Ohio and Mahoning Valley,* and *The Green Cathedral.*

YUKIHIKO NOSE, M.D., Head of Artificial Organs Research at the Cleveland Clinic, was elected secretary of the newly organized International Society for Artificial Organs. He was further honored by being asked to be an editor of the Society's journal.

HART F. PAGE, C.A.E., Executive Director of the Ohio State Medical Association, was recently elected vice-president of the American Society of Association Executives (ASAE), based in Washington, D.C., and secretary-treasurer of the American Association of Medical Society Executives (AAMSE), located in Chicago. He had served on the ASAE Board of Trustees for a number of years; and is a former member of the board of directors, past chairman of the Continuing Education Committee, and current member of the Advisory Committee to the AMA Executive Vice-President of the AAMSE.

Reelected to an AAMSE position was **SIDNEY H. MOUNTCASTLE,** Managing Director of the Summit County Medical Society. He will continue to serve on the AAMSE Board of Directors.

JOHN M. TEW, JR., M.D., Cincinnati, has been named Chairman of the Section of Neurosurgery and Director of the Graduate Training Program in Neurosurgery at Good Samaritan Hospital. Dr. Tew succeeds **FRANK H. MAYFIELD, M.D.**, who held the post for 40 years and who recently became the first recipient of the Harvey Cushing Medal presented by the American Association of Neurological Surgeons. Dr. Tew is president-elect of the Ohio State Neurosurgical Society, chairman-elect of the Section of Cerebrovascular Surgery of the American Association of Neurological Surgeons, and associate chairman of the Joint Committee on Education of the American Association of Neurological Surgeons and Congress of Neurological Surgeons.

JEROME F. WIOT, M.D., Cincinnati, has been reappointed chairman of the American College of Radiology Commission on Diagnostic Radiology. Also elected at the recent meeting of the College is **THOMAS F. MEANY, M.D.**, Cleveland. Dr. Meany will serve as vice-speaker of the Council of the College.

RETURN COMPLETED FORM TO:
Ohio State Medical Association
Department of Field Service
600 S. High Street
Columbus, Ohio 43215

FOR OFFICE USE ONLY:
Box P-_____
Issue:_____

PLACEMENT SERVICE BIOGRAPHICAL INFORMATION

(Please print or type)

1. Name_____ Telephone_____

2. Street_____ City_____ State_____ Zip Code_____

3. Birthplace_____ Date of Birth_____
City-State/Country

4. Citizenship Status_____ Type of Visa_____

5. Marital Status_____ Number of Children_____

6. Medical School_____ Year of Graduation_____
Institution/City/State

7. Internship_____ Year(s)_____
Type/Institution/City/State

8. Residency_____ Year(s)_____
Type/Institution/City/State

9. Fellowship_____ Year(s)_____
Type/Institution/City/State

10. Military (Or Other Governmental) Service_____
Branch

_____ Year(s)_____
Institution/City/State

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*11. Field of Medical Practice_____ *12. Subspecialty_____

13. Licensing Examination: Year_____ State or Territory_____

*14. Date Passed Specialty Board Examination_____

Date Eligible Specialty Board Examination_____

*15. Date Available to Enter Practice in Ohio_____

*16. Area of Ohio in Which Wish to Practice
[See map and circle appropriate number(s)]:

1 2 3 4 5 No Preference ___



*17. Type of Community in Which Wish to Practice:

____Rural ____Suburban Metropolitan ____Inner City
____Rural With Metropolitan Ties ____Metropolitan ____Depressed Economic Area

*18. Size of Community in Which Wish to Practice:

____Under 15,000 ____50,000-100,000 ____500,000-1 million
____15,000-50,000 ____100,000-500,000 ____Over 1 million

*19. Type of Practice Desired:

____Solo
____Group
Small (2-5 members) ____
Large (6-___members)____
No Preference ____

____Part-time Academic Appointment
____Full-time Academic Appointment
Part-time Practice Available____

____Governmental
____Industrial
____Institutional

In order to promote retention in Ohio of physicians who trained in the State, *The Journal,* in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who completed an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of *The Journal.* Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. Information given on this form that will be listed in the ad is noted by an asterisk (*).

If you qualify for this service and wish a classified listing in addition to the usual OSMA Department of Field Service placement assistance, please check here:_____

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits.

The placement form on page 722 is to be completed by any physician registering with the OSMA Department of Field Service Placement Service. The lower portion of the form may be checked if the physician meets the above criteria and desires the classified advertisement listing.

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (Insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

UROLOGIST: Available July 1978. Desires suburban metropolitan area, population 50,000-100,000. Interested in solo or small group practice. Eligible for specialty board examination May 1978. Contact Box P-1 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 15,000 to 500,000. Interested in group practice with part-time academic appointment. Eligible for specialty board examination July 1978. Contact Box P-3 c/o Ohio State Medical Journal.

PSYCHIATRIST: Also general medicine. Available July 1978. Desires location in suburban metropolitan, metropolitan, or inner city community in areas 1, 4, or 5. Population 15,000-1-million. Very flexible as to type of practice. Eligible for specialty board examination July 1978. Contact Box P-6 c/o Ohio State Medical Journal.



INTERNIST: Available July 1978. Desires location in areas 1, 4, or 5 in community that is rural with or without metropolitan ties. Population to 50,000. Prefers group practice with part-time academic appointment. Eligible for specialty board examination July 1978. Contact Box P-8 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1978. Diplomate of the Board of Internal Medicine. Eligible for the specialty board examination in cardiology July 1978. Desires location in areas 1, 2, 3, or 5 in suburban metropolitan or metropolitan community with population 100,000 to 1 million plus. Prefers cardiology group with part-time academic appointment. Prefers invasive cardiology, but willing to do noninvasive. Contact Box P-2 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires location in area 3 in community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000-100,000. Prefers group practice. Eligible for specialty board July 1978. Contact Box P-5 c/o Ohio State Medical Journal.

OPHTHALMOLOGIST: Available November 1977. Desires location in surburban metropolitan community in area 5, preferably Columbus and vicinity. Looking for group practice and academic appointment. Eligible for specialty board examination 1977. Contact Box P-7 c/o Ohio State Medical Journal.

INTERNIST: Subspecialty in pulmonary medicine. Diplomate of the Board of Internal Medicine. Eligible for specialty board examination in pulmonary medicine June 1978. Desires location in community that is rural with metropolitan ties, suburban metropolitan, metropolitan, or inner city. Population 15,000-1 million plus. No preference as to area of state. Very flexible as to type of practice. Contact Box P-9 c/o Ohio State Medical Journal.

SURGEON: General with thoracic and cardiovascular subspecialty. Available December 1977. Desires community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000 to 500,000. Eligible for board examination in general surgery 1975. Contact Box P-4 c/o Ohio State Medical Journal.



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EMPRACET® with Codeine Phosphate, 60 mg, No. 4 Ⓒ

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.

WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing EMPRACET® c̄ CODEINE #4

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg. Ⓒ

Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet c̄ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet c̄ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet c̄ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® c̄ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.

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Burroughs Wellcome Co.
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Classified Ads

Rates: $2.00 per line. Display classified: $4.00 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

WANTED: Part-time (approximately 20 hours per week) general physician, preferably interested in human behaviour modification, to assist in a multicenter national collaborative clinical outpatient trial at the University of Cincinnati Medical Center. Ample research opportunities and academic setting. Pleasant working conditions. Remuneration commensurate with background. Reply Box 811 c/o Ohio State Medical Journal.

MOBILE RADIOGRAPHIC X-RAY FACILITY: For sale or lease, in excellent condition. Completely self-contained x-ray laboratory consisting of a 22-foot, air-conditioned and vandal-protected Winnebago van, condenser-discharge x-ray system with tubestand and table, Dupont daylight film-loading system, Kodak automatic cold-water film processor and all accessories. Very useful for care of nursing home patients, industrial screening examinations, athletic events, or disaster work. Contact Drs. Perilla, Sindler, & Assoc., P.A., 3350 Wilkens Avenue, Baltimore, MD 21229.

LIMA STATE HOSPITAL, a 400-patient Forensic Center, has positions available for physicians and psychiatrists to work in administrative, clinical, or staff capacities. Salaries range from $30,000 to $50,000 commensurate with qualifications, education, and assigned functions. An Ohio license or eligibility for a license is a requirement. For more information, please submit vitae to: Personnel Office, Lima State Hospital, Drawer Q, Lima, Ohio 45802. Telephone: 419/222-5075.

PEDIATRICIANS WANTED: Excellent opportunity for one or two board certified or eligible pediatricians. We have guarantees, office space, computerized billing, and office organizational business assistance available for the right physicians. City of 18,000 with growing service area of 38,000. Close to Cleveland, and very good recreational areas- sailing, skiing, tennis, all locally. New office available within one to two minutes walk of hospital. Contact Patrick J. Martin, at Fisher-Titus Memorial Hospital, 272 Benedict Avenue, Norwalk, Ohio 44857.

GENERAL INTERNIST: Board eligible, two years' experience in private practice and two years' full-time ER work. ACEP member. Willing to practice general medicine and/or ER work full- or part-time. Licensed in Ohio and Illinois. Consider any location. Reply Box 810 c/o Ohio State Medical Journal.

FAMILY PRACTITIONERS NEEDED: Growing community of over 4,000 needs one or two M.D.'s. Two F.P.'s in town and one nearby. Join existing practice or solo available. Excellent recreational and economy. Sixty miles from metro-cities, 57-bed J.C.A.H. hospital in community. Trade area of over 12,000. Contact L. Wattier, Administrator, Memorial Hospital Inc., 104 W. 17th, Schuyler, Nebraska 68661, phone: 402/352-2441.

MEDICAL DIRECTOR: Large life insurance company with home office in suburban Cincinnati area seeks physician capable of assuming position of Medical Director. Certification in internal medicine and/or insurance medicine desirable. Minimum of three years' medical underwriting experience required for this challenging position. Salary negotiable depending on qualifications plus full package of benefits. Reply in confidence to Box 806, c/o Ohio State Medical Journal.

PHYSICIAN'S ASSISTANT: Graduate AMA-approved Lake Erie College/Cleveland Clinic Baccalaureate Program. Clinical experience in all primary care disciplines. Call 216/381-7349 or write E. McM., 1645 Maywood, S. Euclid, Ohio 44121.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement of the physician's assistant and assumes no responsibility for the statements made.)

FOR RENT: South End, Cols. Estab. G.P. office: 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

OBSTETRICS AND GYNECOLOGY: Unexpected opening in OB/GYN for a first-year resident (Grad II) — 700-bed hospital with medical school affiliation known for its postgraduate medical education in all phases of medicine. The position is available July 1, 1978. Reply Box 809 c/o Ohio State Medical Journal.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

STAFF PSYCHIATRIST: Position available at 85-bed, state psychiatric hospital. Receiving and acute care services, also occasional extended care cases. Hospital has two-year accreditation as a psychiatric hospital by the JCAH. New 30-bed wing under construction. Potential for challenging program development.

Ohio license and board-eligible or board-certified in psychiatry and neurology required. Salary range $40,000-$45,000. Liberal fringe benefits and retirement plan. Scenic area of Ohio. Outstanding recreational facilities in vicinity. Hospital located on southern border of Ohio. Population 26,000. Call or write Henry Hogan, M.D., Medical Director, Portsmouth Receiving Hospital, 25th and Elmwood Road, Portsmouth 45662, phone: 614/354-2804.

ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

FOR SALE—EXCELLENT OPPORTUNITY: Columbus, corner lot, next door to Mount Carmel Medical Center West. Large enough for doctor's or dentist's office, medical laboratory, or drug outlet. Call evenings after 7 PM: 614/870-6189 or 274-9791.

INTERNIST AND PHYSIATRIST: For professional corporation in large cities, State of Ohio. Ohio license a must. Board certified or eligible. Fringe benefits available. Salary commensurate with experience. Contact: Alex Fouras, M.D., Director, Allied Medical, Inc., 1925 E. Dublin-Granville Rd., Columbus, Ohio 43229. Phone 614/846-8434.

EMERGENCY MEDICINE: Career opportunities available in E.D. medicine. Also short-term and locum tenens. Eight Ohio locations. Flexible work schedules and competitive remuneration. Paid malpractice, vacation, educational leave. Contact Doctor S. Spurgeon or J. W. Cooper toll-free 1-800-325-3982.

E.N.T.: Unexpected retirement has created immediate need for board-qualified ENT physician. Excellent community, excellent hospital. Facilities and equipment available. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third physician. New facility. Excellent hospital within walking distance. Contact Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

PSYCHIATRIST: For community mental health center using case-manager model. Begin $41,600. Board eligible. 32 hours per week. Private practice allowable. Liberal fringes. Moving expenses. Open October 1, 1977. Resume/three reference letters to Personnel, Scioto Paint Valley Mental Health Center, 50 Pohlman Road, Chillicothe, Ohio 45601, telephone 614/775-1260.
EQUAL OPPORTUNITY EMPLOYER

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

MARION, OHIO: Excellent opportunities to practice medicine. Existing and new, solo, partnership, and association. 250-bed, excellently equipped, regional-medical-center hospital within walking distance from offices. Industry and agriculture support city/county of 65,000 and total trade area of 250,000 people. Excellent schools, 50-minute easy drive to Columbus, reliable cross coverage.

OB/GYN
FAMILY PRACTICE
INTERNAL MEDICINE
PEDIATRICS
GENERAL SURGERY
PHYSICAL MEDICINE

Send CV or contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302. Phone 614/382-8211 or 382-3442.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

EMERGENCY ROOM PHYSICIAN: Immediate positions available for emergency room physicians at Medical Park, in Wheeling, W. Va. Centrally located between Pittsburgh and Columbus. Our new, 286-bed hospital has been operational since June 1975 and houses an ultramodern emergency care center. University affiliation, congenial staff, excellent fringe benefit program. Salary negotiable. Send curriculum vitae to G. M. Kellas, M.D., Medical Director, Wheeling Hospital, Medical Park, Wheeling, W. Va. 26003.

THREE BOARD-CERTIFIED FAMILY PHYSICIANS looking to recruit family physician graduate or board-qualified or certified family physician as an associate in a semi-rural small town, group practice. Progressive community; local liberal arts college; excellent local community hospital; and 35 miles from Columbus, Ohio. A very good setting in which to practice, live, and raise a family. Contact Granville Medical Center, Inc., Granville, Ohio 43023, phone 614/587-0115.

EMERGENCY DEPARTMENT PHYSICIAN-CLEVELAND, OHIO: New emergency group desires career-minded emergency physicians. Opportunity is unlimited. Superior starting salary; vocational and educational leave; malpractice and hospital insurances paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal, M.D., President, Medical Emergency Services, Inc., phone: 216/398-4141 ext. 388, or 216/831-4095.

PSYCHIATRIST: Half-time, for a Health Maintenance Organization. Attractive fringe benefits. Reply Box 802 c/o Ohio State Medical Journal.

physicians, consider a practice in south carolina.

* low malpractice insurance rates, * the opportunity to join a group or partner or establish a new practice in a rural or urban area, *continuing medical education through a system of Area Health Education Centers, as well as two medical schools, * lower taxes, * lower cost of living, * access to both mountains and beaches, and * a mild climate

For information about specific practice opportunities in South Carolina, contact:
Rural Health Delivery Project
P.O. Box 11188
Columbia, S.C. 29211
(803) 779-7264

NOVEMBER 1977
Volume 73, Number 11

THE OHIO STATE Medical Journal

A helping hand . . .
THE OSMA PHYSICIAN EFFECTIVENESS PROGRAM



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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

General Assembly Considering Certificate-of-Need Legislation

The Ohio General Assembly is considering certificate-of-need legislation in both the House (HB 864, Eckart, D-Cleveland) and the Senate (SB 349, Valiquette, D-Toledo). Although the Legislature has been in recess, work on these bills has continued. A subcommittee in the House and staff in the Senate are working on the provisions of the bills. Action on either bill is not expected before January 1978.

In September 1977, the finance committees of both houses held hearings. The OSMA Department of State Legislation and OSMA District Four Councilor C. Douglass Ford, M.D., have expressed the OSMA's concern via testimony at all hearings to date.

These bills have received enthusiastic endorsement from groups such as the Ohio AFL-CIO, General Motors, Nationwide Insurance, United Auto Workers, and Blue Cross. During testimony, Blue Cross recommended that the expenditure level for certificate-of-need review be lowered from the $100,000 limit (currently in both HB 864 and SB 349) to $50,000.

The OSMA believes that Ohio's certificate-of-need program should parallel the federal certificate-of-need regulations. The federal law contains a $150,000 threshhold for review by the local health systems agency. Last week, a committee of the U.S. Senate defeated a proposal to specifically include physicians' offices in one of the cost-containment bills. HB 864 and SB 349 call for expenditures by private physicians in excess of $100,000 to be reviewed by the local health systems agency. The OSMA will attempt to have private physicians' offices excluded from Ohio's certificate-of-need legislation.

State legislative action in this area is mandated by federal law requiring states to have federally approved certificate-of-need programs in place before July 1, 1978. If such programs are not in effect, the state will not qualify for federal financial aid to state health service projects. The Ohio Department of Health is the designated planning agency in Ohio. The Department is promulgating rules through the Public Health Council to meet the federal requirements. The sponsors of the legislation now before the General Assembly believe the Department of Health has waited too long to promulgate the regulations.

The development of a certificate-of-need program in Ohio is confusing because the House, Senate, and Public Health Council are all working on the same issue at the same time. The OSMA Department of State Legislation will be working closely with the House subcommittee and the Senate staff to exclude physicians' offices from the certificate-of-need legislation.

Your Help Is Needed

The certificate-of-need bills have raised several questions about the type and the cost of equipment being placed in physicians' offices. The OSMA would like to compile a list of capital equipment being utilized by Ohio's physicians in their offices. We need your help.

Write the OSMA, listing the name or type of capital equipment and its cost. List those medical equipment items that fall into these ranges:

Over $25,000 but under $50,000;
Over $50,001 but under $100,000;
Over $100,001 but under $150,000; and
Over $150,000.

Some legislators are unsure that $100,000 is the appropriate minimum for review. They would like to know how much more equipment would be covered if the limit was reduced to $50,000 as suggested by Blue Cross. Others feel the limit should be raised to $150,000 because of the necessary equipment that will soon cost over $100,000 but less than $$150,000. This listing will show the legislators the type and the cost of equipment currently in use in private physicians' offices. The compiled list will not include the name of the physician or his address, only the type and the cost of medical equipment.

Please forward this information to EQUIPMENT ANALYSIS, The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215. Send the information by December 1, 1977.

Election Year Coming Up

It is not too early to begin making your contacts with state legislators for the 1978 election campaign. Physicians and their spouses who will be working in state legislative campaigns should contact the OSMA Department of State Legislation. We will be working with you to organize "key physicians" and physician-support committees. The only way you will have a legislative impact in 1979 is to work on a campaign in 1978!

Patients' Bill of Rights Approved

The Senate has approved the amended version of SB 202 (Valiquette, D-Toledo), the so-called "Hospital Patients' Bill of Rights." Although the OSMA opposes SB 202, the amended version deletes most of the major objections of the OSMA. Provisions containing mention of direct access to the courts for rights violations and interferences in the physician-patient relationship have been removed. The OSMA does not oppose patients' rights, but rather the codification of standards of practice. This legislation has strong political pressure behind it, and bipartisan support enabled the bill to pass the Senate.



the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Health Care Legislation From the Carter Administration

The Carter Administration is setting the stage for a big push for national health care legislation. Numerous task forces of health planners in the Department of Health, Education, and Welfare (HEW) are conducting hearings in all HEW regions (Columbus, Ohio October 6, 1977), with ten hearings slated in HEW's Midwest Region.

Back in Washington, other task forces of health planners are busy drafting various approaches to national health insurance (NHI). About the only certainty at this stage is that the Carter bill will call for implementation in stages to avoid a crushing financial burden on the federal treasury, not to mention the federal taxpayer. Carter, stung by sharp, public criticisms from social welfare forces that supported his candidacy and now claim he has turned his back on them, could use a legislative campaign for NHI to help placate his critics.

Few expect Congress can do more next year than take a good look at NHI. The awkward jurisdictional tangle in Congress, where two committees in both House and Senate must share jurisdiction, makes for delay. With lawmakers anxious to get the session over quickly so they can campaign for the 1978 elections, only the most sanguine NHI proponents predict final congressional action next year.

Analyzing the NHI situation for the benefit of Congress, the Congressional Budget Office (CBO) issued a report warning that "If strategies to contain health expenditures are not adopted soon, the possibility of enacting a comprehensive national health insurance program may be adversely affected."

In addition to Carter's Hospital Cost Containment Plan, Congress was faced with numerous other health issues in the final weeks of the 1977 session. (See *The Journal*, Vol. 73, No. 9, September 1977, page 589.) The HEW appropriation was stalled over the abortion issue. Also pending were new federal regulations for clinical laboratories; Medicare-Medicaid fraud and abuse; federal aid for rural health clinic physician extenders; the Administration's plan for expanding the child health program; and an omnibus drug bill making many changes in Food and Drug Administration (FDA) operations and regulations, including new labeling language.

Some of these bills were fated to remain lodged in Congress until 1978. The only sure bet for passage in 1977 was the appropriations bill which gives HEW several billion dollars more than President Carter recommended and continues to bar federal Medicaid payments for most abortions.

Other major health bills before Congress included an 18-month delay in the proposed FDA ban on saccharin, amending the renal disease program to encourage self-dialysis and kidney transplants, establishing a separate Department of Health, and freeing federal scholarship stipends from income tax.

A gloomy report by the CBO on health spending advised House and Senate Budget Committees that current cost control efforts "will apparently have little effect on the upward trend in health expenditures . . . . " The report said existing reimbursement, facility, and utilization containment programs can be altered by increasing or decreasing the level of regulation. "Changes must be made in hospital reimbursement practices if some immediate impact on hospital expenditures is to occur," the report stated.

According to the CBO:

> A successful program, whether administered at the state or federal level, would have to break the automatic cost-increase/revenue-increase relationship that is currently enjoyed by individual hospitals. Certificate-of-need programs could be strengthened through increased financial support for the state agencies, more precise federal guidelines, and perhaps limits on capital spending. The cost-effectiveness of PSROs might be improved by restricting utilization review to more questionable medical practices or by emphasizing preadmission review.

The way the CBO sees it:

> The expansion of regulatory efforts is an attempt to compensate for the over-utilization of health care and the failure of high costs to lessen demand. Appropriate changes in the underlying supply and demand factors could reduce the need for hospital regulation. Moreover, because these supply and demand factors operate throughout the entire health sector, successful containment of hospital expenditures might accelerate non-hospital expenditures. Increases in patients' out-of-pocket costs or limits on physicians' fees might, however, increase price-consciousness related to non-hospital care.
>
> Federal regulatory efforts to contain the supply of resources have concentrated on beds and facilities, virtually disregarding manpower and technology. While prospective reimbursement and utilization control programs can be strengthened and thereby reduce health expenditures, their effectiveness may be limited without national health insurance, because of the number of third-party payers and the variation in their payment procedures. Supply policies, however, might be quite effective without national health insurance. (Countries with national health insurance plans are relying increasingly on constraints in supply to contain health expenditures.)

Future growth in the number of physicians could be reduced, particularly by restricting the influx of foreign medical graduates, stated the CBO.

It added:

> Because each additional practicing physician generates expenditures for both hospital and physician care far beyond the level of his net income, strategies to reduce the impact of each physician on total expenditures could be considered. Altering reimbursement schedules and increasing the proportion of physicians in primary care and in prepaid health plans are possible strategies.

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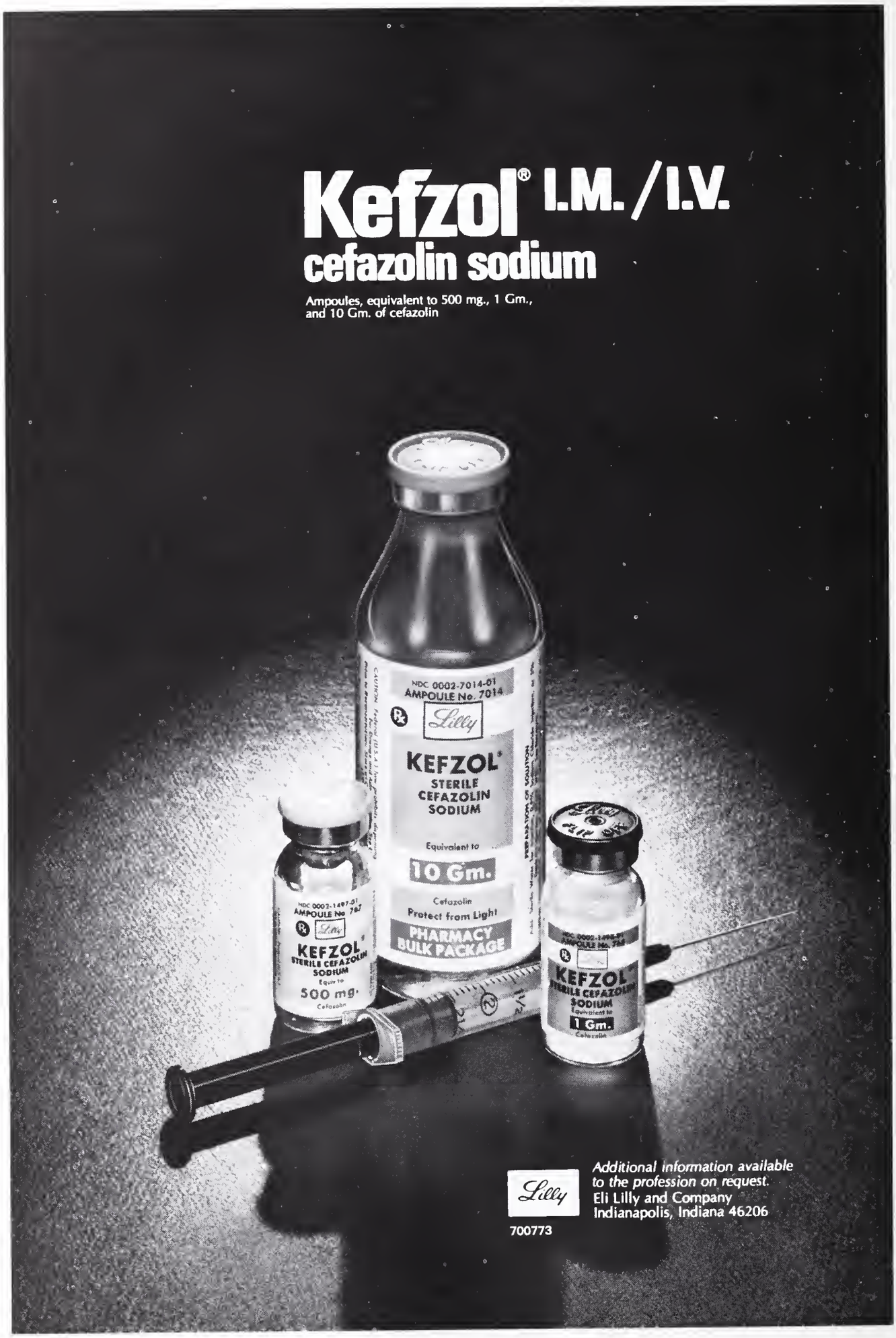
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COVER: This issue of ***The Journal*** is devoted to the Ohio State Medical Association Physician Effectiveness Program. This program is a leader in the decision that physicians themselves should help those among their ranks beset by problems. All related articles are listed under the heading "Clinical and Scientific Articles."


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THE OHIO STATE Medical Association Clinical and Scientific

The OSMA Physician Effectiveness Program

Milton M. Parker, M.D., Chairman,
Ohio State Medical Association Committee on Mental Health

ALTHOUGH THE NEED had been apparent for many years, it was only recently that medical associations, the Ohio State Medical Association being one of the leaders, formulated programs for the detection and recognition of physicians with disabling problems. Guiding the afflicted physician in an effective yet dignified manner, while helping him realize his dilemma, did not previously appear to be an urgent obligation to those "in charge." In fact, more often than not, such a matter was sidetracked on the belief that only "those closest to the patient" should be obliged to deal with the problem. This dodge almost always succeeded in procrastination and in compounding the initial problem. "Those closest" have traditionally been involved in the life of an impaired physician in a way that rendered them ineffectual — much as if they had somehow become entwined and entangled in the same web.

For a very long time, there was a perplexity as to: "Who will tell him or her?" or "Will he/she listen?" or "What if he/she begs off and asks for some time to help himself?" Such obstacles, ad infinitum, have generally rendered the outlook of hopelessness about the case of an impaired physician. Therefore, the ultimate outcome, in some instances involving revocation of medical license or suicide attempts, is not at all surprising.

Such extreme escalation of problems related to physician impairment revealed that opportunities for sensible and effective intervention should not be wantonly forfeited. Because of the nature of his problem, the impaired physician could not help himself. And, in spite of its regulations or intentions, society had no means for coming to grips with such problems in their earlier, therapeutically advantageous phases.

Approximately 3½ years ago, the OSMA Committee on Mental Health concerned itself with the problem of the impaired physician. The charge to which the Committee responded originated within the minds and hearts of its membership. The prevailing theme, expressed in many diverse ways, can be summarized as "I am my brother's keeper." From the beginning, the positive approach was expressed as illustrated by the title of the OSMA program: "The Physician Effectiveness Program."

As is apparent in the following presentations, certain fundamentals were established at the beginning of the program.

1. The whole undertaking was a purely voluntary plan, devised as a labor of love and commitment, with each participating physician giving of himself and his time as feasible and at his own expense.

2. Recognizing that calls for help might originate at any time in any area of the State of Ohio, we attempted complete volunteer coverage by districts. However, aware that a prior personal or professional relationship might impede the initial contact, it was agreed that any volunteer might reasonably request not to be assigned in a given instance.

3. Volunteers should be of such personal and professional maturity that making an effective initial contact, as well as following through, would constitute a personally comfortable assignment. Also, such maturity would enable the troubled physician to understand the spirit of friendship and helpfulness being offered. This feature alone has accounted for many positive responses in situations which would otherwise have remained "hung-up."

4. Any approach to an impaired physician would, at no time, utilize coercion or the threat of punitive measures. Only in the very last instance, would a reference be made to the Ohio State Medical Board.

During the 1977 Annual Meeting of the Ohio State Medical Association, the House of Delegates passed Resolution 80-77 entitled "Physician Effectiveness Programs." This resolution encourages expansion of the Physician Effectiveness Program through local county medical societies and through cooperation with Ohio specialty societies and other interested groups. The Committee on Mental Health and the members of the OSMA Physician Effectiveness Program stand ready to assist in this expansion.

It is with a profound sense of pride and with genuine personal gratification, that I introduce you to our pioneering "Ohio Plan." The philosophical and practical exemplification of an ancient, Biblical injunction is surely the groundwork of the OSMA Physician Effectiveness Program.

Dr. Parker, Columbus, Chairman, Department of Psychiatry, and Senior Attending Staff, Riverside Methodist Hospital; and Clinical Professor of Psychiatry, The Ohio State University College of Medicine.
Submitted July 11, 1977.

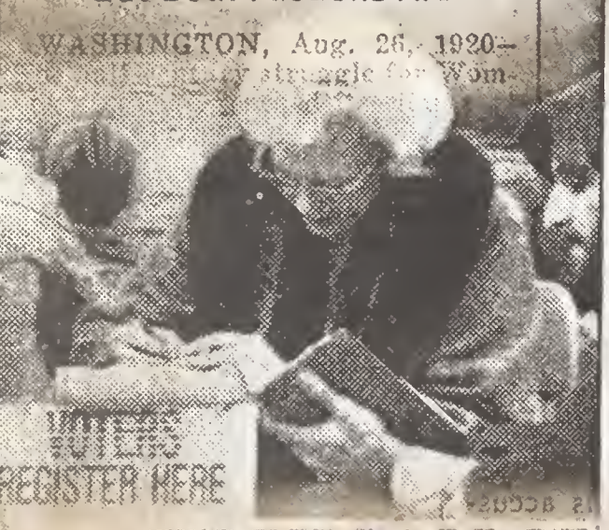
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Ca the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, 1
The Social Security Bill, prov
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SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0, and sen

TRUMAN CLOSES TED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W. WASHINGTON, D. C. 20005

The OSMA Physician Effectiveness Program

How It Operates

Robert D. Clinger, OSMA Assoc. Executive Director

The Ohio State Medical Association Physician Effectiveness Program was established on July 1, 1975 for the express purpose of aiding physicians who develop problems such as alcohol or drug addiction or mental illness. The program is organized by means of three options for extending assistance to impaired physicians. Personnel involved include the chairman of the program, an OSMA staff member, and district liaison physicians. In addition, family members of the impaired physician, hospital administrators, and medical executives could enter into a particular case.

All assistance is triggered by calling the established OSMA telephone number (614/228-6971) and asking for the Physician Effectiveness Program staff person.

Regardless of the option, the work of the volunteer "district liaison physician" (DLP) is most vital to the operation of the program. Following the initial call to the OSMA staff person, the DLP must first determine whether or not the physician has a bona fide problem. He then serves as confronter and urges the physician to acknowledge his problem and to begin treatment. The DLP will do everything possible to convince the physician of the magnitude of his problem. If this fails, the DLP is empowered to recommend that the case be turned over to the Ohio State Medical Board for investigation.

The Physician Effectiveness Program is guided by six general principles:

1. Be motivated by humanitarian concerns for the public and the impaired physician.
2. Recognize that alcoholism, drug abuse, and mental illness among physicians are too often ignored or untreated.
3. Recognize that alcoholism, drug abuse, and mental illness are treatable conditions— and that treatment and rehabilitation personnel skilled in these areas have a good success record.
4. Encourage all impaired physicians to seek help and cooperate in treatment at the earliest possible time in order for them to retain or regain full effectiveness to practice.
5. Employ *constructive coercion* if a physician refuses all offers for assistance at a time when his impairment poses a threat to reasonable delivery of medical care.
6. Employ *involuntary coercion* where all (other) efforts have failed and the physician's impairment threatens the public or physician's health.

Option I of the Physician Effectiveness Program is for the physician who realizes that he or she has a problem and desires counseling or treatment. As might be expected, Option I is seldom employed since most physicians with a problem initially deny that it exists.

Option II is used in most of the contacts. Under this option, a peer-colleague indicates that a problem exists. In the two years since the program began, a large number of contacts have also come from family members, hospital administrators, and medical executives.

Option III separates from Option II at the point where confidential, written communication between the chairman of the program and the impaired physician does not convince the physician to seek treatment. At this point, the potential for an investigation by the Ohio State Medical Board is carefully outlined and the physician is again urged to seek treatment as soon as possible.

Option I

When the impaired physician himself seeks guidance and referral through the OSMA, the following sequence of events results under the provisions of Option I of the program:

1. The impaired physician calls the established telephone number of the OSMA; gives his name, address, and telephone number; and indicates his desire for medical help.
2. The appropriate staff member contacts the DLP.
3. The DLP contacts the impaired physician, inquires about the nature of his illness or problem, and discusses appropriate evaluation and treatment arrangements.
4. The DLP contacts the psychiatrist or other physician considered most appropriate to care for the impaired physician and informs him of the general nature of the problem.
5. The impaired physician enters treatment with the attending physician, ending the OSMA's involvement.

Option II

The option also exists for a concerned peer (another physician practicing in the same community) to contact the OSMA regarding the possibility that a fellow physician might be ill and in need of assistance. In this case, the following sequence of events results through Option II:

1. The concerned peer calls the established telephone number of the OSMA, giving his own name, address, and telephone number; the name of the colleague whose health is considered questionable; and the specific reasons for concern. The initiating physician will be guaranteed subsequent anonymity, but should be required to identify himself to assure that he is indeed a physician in order to minimize the risk of frivilous or vindictive calls.
2. The appropriate staff person contacts the DLP.

3. The DLP checks with the appropriate individual or committee of the local county medical society to determine whether, in the society's judgment, there is sufficient reason to believe the physician in question to be ill. This does not require any initiative on the part of the county medical society, but simply confirmation from it that other physicians share the concern that this colleague might be ill.
4. The DLP reports to the chairman of the program that sufficient cause exists to justify contacting the physician thought to be ill.
5. Such contact is first made in writing by the chairman, explaining the nature of the OSMA program, the general circumstances leading to the letter (preserving anonymity for all individuals involved), and stressing the desirability of the physician seeking appropriate evaluation and treatment. This letter indicates that the DLP will contact the physician personally to make appropriate arrangements.
6. The DLP contacts the sick physician and offers to help if any problem exists.
7. If the physician in question acknowledges his illness and need for assistance, the DLP makes arrangements with an attending physician to evaluate and to treat him as necessary.
8. The impaired physician enters treatment as agreed between himself and the attending physician.
9. The only further contact between the attending physician and the DLP is the former's confirmation that the sick physician is indeed undergoing appropriate treatment.
10. The DLP reports to the chairman that no further action on the OSMA's part is indicated. Thus, no contact is made with the Ohio State Medical Board.

Option III

In some cases, the physician whose health is in question may deny any illness and refuse suggestions of evaluation or offers of treatment. Under this circumstance, Option III must be employed. This option follows Option II through step six, where it differs as follows:

7. If the physician in question denies any illness or refuses assistance, the DLP reports this to the chairman. Similarly, if the physician in question agrees to see the attending physician, but does not do so, a report of this action is made.
8. After a suitable interval, the chairman again writes to the physician in question, urging him to seek assistance and pointing out the program's responsibility to report the situation to the Ohio State Medical Board if no corrective action is taken voluntarily.
9. The DLP follows with telephone contact, stressing the same points as the chairman.
10. If the physician in question still denies illness or declines assistance, the DLP again reports to the chairman. The chairman communicates the facts of the case to the Ohio State Medical Board, preserving the anonymity of the original concerned peer and of specific individuals contacted by the DLP in the local county medical society. The OSMA's involvement ends at this point.

Under all options of the OSMA Physician Effectiveness Program, the goal is to assist the impaired physician so that he can preserve his own health— thus, allowing him to proceed in his primary mission of treating patients in the most effective manner. This will benefit his patients, family, and friends alike. Any questions regarding the Physician Effectiveness Program should be directed to the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, telephone: 614/228-6971.





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The Physician Alcoholic

ARCH to Recovery

Perry R. Ayres, M.D.

I REMEMBER MIKE *as an outgoing, white-haired, apple-cheeked man with a boyish grin. Although we were not close friends, our paths crossed frequently, and I always felt comfortable with him. Well-trained in medicine, he kept up with current developments, served willingly and well on many hospital committees, held offices in our Academy of Medicine, and was often involved in community health activities. He had a large following of devoted patients whom he served in the best traditions of family practice. Mike was born and raised in our community, and he had a host of friends, but his social life was quiet. He was a devout Catholic and a family man who enjoyed attending church affairs with his wife and their several children. He was very well thought of by one and all.*

Mike died when he was about 50 years old and was buried with quiet ceremony. There was no public announcement of the cause of death. Some time later, however, we were shocked to learn that he was alcoholic and had died of barbiturate overdose, possibly suicidal. Only then did bits and pieces of information from the last year or two begin to have meaning. I had seen very little of Mike for several months before he died. On a few brief encounters, he had seemed tired and less ebullient than usual and had fussed uncharacteristically about the stresses of his practice. He had failed to show up for several meetings and had declined a couple of committee assignments. There had been rumors that one of his sons was having adjustment problems, and his favorite daughter was entering a convent. His previously slender, vivacious wife had gained a lot of weight and appeared anxious and depressed. Some of his old patients complained of difficulty reaching him and of his curt behaviour. Much later, a nurse told of an unintelligible, nocturnal conversation with him when she called to verify an order. In retrospect, it was clear that Mike had been in serious trouble for many months. We learned that he had neither sought nor been offered assistance by his colleagues — and we were very sad.

Now, I don't know why Mike was alcoholic, but I do know that he was not a "bad" man. He was a sick man, and his sickness had profound effects upon those nearest and dearest to him and carried the potential for danger to his patients. Compounding the tragedy is the sad fact that neither he nor we could recognize the clues to his illness that are so clear in retrospect. Had it been otherwise, this fine man might have been offered treatment.

Mike's story is a composite of several physicians I have known or attended. It might have been about meperidine, barbiturate, or amphetamine addiction, or some combination of these. Perhaps it should have included, "I know I've got a problem, but I like my problem," a statement recently made to his distraught wife by a prominent colleague who is still courting disaster with alcohol and amphetamines. It might have been the story of a young man whose drug abuse began while he was in medical school and continued for years before disaster struck. It might have been about the anesthesiologist, who combined her medical career with that of wife and mother until her alcoholism destroyed both careers. Or about the small-town practitioner, whose colleagues, in the pressure of their own busy lives, covered for him during frequent unexplained absences thus, unwittingly enabling his addiction to progress. Or the pathologist functioning well in his hospital job by day, who drank himself into a stupor in the seclusion of his study every night for years, and whose problem surfaced only after his wife suffered a psychotic breakdown. The futile efforts of family and colleagues might have been mentioned as in the case of the unemployed and unemployable industrial physician, whose wasted and scarred body was found in a motel surrounded by an assortment of syringes, bottles, and vials after he disappeared from a hospital during his 12th admission for problems related to his addiction.

Mike's story could have included a confrontation by a committee of concerned colleagues, apprising him of his difficulty and urging that he seek treatment. Or, it might have included a confrontation followed by kind-but-firm insistence that he take a leave of absence from his practice, undertake a prescribed program of treatment and rehabilitation, and then seek permission to resume practice. Just possibly, the ending might have been a happy one.

Industrial alcoholism programs feature just such confrontation. Employees are apprised of their work records and are then given firmly limited options — be fired or seek treatment. Large numbers of valuable employees are

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being salvaged, not to mention benefits in terms of morbidity, mortality, and quality of the lives of employees and their families.

Several state medical societies, notably Georgia,[1] have launched ambitious programs for dealing with physicians impaired by addiction to alcohol and other drugs. The Physician Effectiveness Program of the Ohio State Medical Association is one of these.[2] Operational since July 1975, it is slowly gaining momentum. Briefly, it is a three-stage program providing for the identification and confrontation of impaired physicians by their peers and presentation of the options of voluntary treatment on the one hand or notification of and action by the Ohio State Medical Board on the other. Its aim is to protect his patients and himself while the physician seeks treatment and proves he is stable.

This program can and must work, and the scope of its activities will enlarge as it proves its effectiveness. Volunteers performing the field work of the program need talents of a sort that are difficult to teach — empathy, wisdom, patience, and faith. They especially need the wholehearted support of their colleagues. It is time that every physician in Ohio take a fresh look at the problem of the impaired physician and start by re-examining his attitudes, for it has been said that "the attitude is the father of the action."[3]

ARCH

Performance of a physician can be impaired by many things — by senility, by ineptitude, by incompetence, by dishonesty, for example, but those accessible to treatment are psychiatric disorders, drug addiction, and alcoholism. It is the latter two that are mentioned most often, and it is the alcoholic physician who is most readily identified. The remainder of this paper will be limited to consideration of some principles and attitudes I consider essential to the treatment of alcoholic patients, although some have wider application. They are represented by the acronym ARCH for **Acceptance, Recognition, Confrontation, and Hope.**

Acceptance of the concept that alcoholism is a treatable disease does not come easily to some physicians. Although practical experience of Alcoholics Anonymous and of alcoholism rehabilitation facilities teaches us that acceptance of the disease concept by both patient and therapist is a major factor in restoring patients to sobriety and to function, there have been two major obstacles for many physicians. First is the traditional moralistic stance, which says "while man may be the victim of his vices, he is also their author."[4] No doubt. But this begs the issue. While it may say something about drinking, it says little about alcohol*ism* or about the fact that only about 10 percent of Americans who drink develop "preoccupation with alcohol," as described in the American Medical Association definition,[5] and follow a fairly predictable course in terms of compulsion, progression, relapse, and unmanageability of their lives. The alcoholic patient is a *sick* man trying to get *well,* not a *bad* man trying to get *good.*

The other stumbling block is the notion that alcoholism is simply a symptom of underlying psychologic problems and that correction of these will remove the need for the alcoholic to drink. No doubt there are underlying problems, but this thesis disregards abundant evidence to the effect that the problems cannot be efficiently attacked until the preoccupation with alcohol is controlled, and that the problems may be resolved in the process.

Regardless of how alcoholism begins or what sort of person the alcoholic was before, it is important to recognize that alcoholism produces, in a sense, a different person — a distortion of the original. The real person cannot be perceived by himself or by others until and unless he has been released from the effects of the drug and from preoccupation with its use.

Read Mike's story again.

Recognition of alcoholism requires high levels of suspicion and empathy as well as awareness of the fact that it disrupts every aspect of the patient's life and usually of those close to him. The alcoholic and his family frequently don't recognize alcoholism as the cause of increasing problems in their lives, and they seek help reluctantly and late when they do. This is especially true of physician alcoholics and their families. Alcoholism is a stigmatized disease.

Mechanisms are available for identifying the physician alcoholic through impaired professional performance, but such impairment often is not evident until late in his course. Long before this, his family and close friends have known he was in trouble. Not being aware of the inevitable and relentless progression of his disease, fearing disgrace and financial disaster that might result from disclosure, and just simply hoping it will all work out, they keep silent and their sickness progresses along with his.

Physicians sometimes treat patients without considering the fact that alcoholism may be causing or contributing to the hyperlipidemia, the obstructive pulmonary disease, the depression, the paranoia, for example. Furthermore, behavioral manifestations, often obnoxious and deceitful, are difficult to comprehend as symptoms of a potentially fatal disease; they may even cause us to reject the patient. We tend to overlook alcoholism even though its effects—physical, psychological, social, and spiritual—are quite evident. A syndrome is identifiable. "What causes problems is a problem.[3]

Mike's story is replete with clues.

Confrontation of the patient with the facts of his illness requires an attitude of firm kindness, sometimes called "tough love." Principles and procedures have been spelled out admirably by Maxwell[6] and Johnson,[7] and their books, although not available in most medical libraries, are highly recommended reading for anyone contemplating such an endeavor.

The object of confrontation is to overcome the

arrogance and the powerful denial mechanism operating in the alcoholic by bringing him "messages from reality."[6] Then, he may become receptive to treatment. Here is where empathy, wisdom, patience, and faith are put to the test. We may fail and it may be necessary to repeat the confrontation again and again until that time when the unmanageability of his life is so painful that he will surrender and comply. Meanwhile, he and his family probably will suffer a great deal, and he may well die by suicide, by accident, or by the late effects of alcoholism before ever letting go of his compulsion. Alcoholism is a fatal disease, make no mistake about that.

When the physician alcoholic has progressed to the point where professional competence is impaired and this has been recognized by his peers, confrontation can proceed along lines similar to those used by industry, and he can be led or forced into treatment. He is faced with the reality of his unmanageability, is presented with firmly limited options, and is made responsible for his choice. This is not to say that he always accepts the evidence, even when it is overwhelming (that is part of his sickness), or that he always accepts treatment.

It is important that evidence presented at confrontation be as factual and explicit as possible. General references to "impaired performance," "work not up to your (or our) usual standard," and other faults may be challenged in the manner of that old barroom cliche, "I can whip you with one hand behind my back!" Such is the nature and power of the denial mechanism so characteristic of this disease that some physician alcoholics threaten legal action against their "persecutors," not recognizing their own vulnerability to legal action by the State Medical Board. This is reminiscent of that other barroom challenge, "I dare you to step outside and say that." Some may reject confrontation and treatment by simply retiring, moving to another state, or going into a type of work where peer approval and medical licensure are not essential — and by continuing to drink. Such hazards and disappointments should not deter us. At least, we tried,

Of course, it would be far better if family and friends, who almost always know of the problem before professional competence is affected, could become sufficiently informed and so resolute that they would initiate confrontation earlier in the hope of saving the physician, themselves, and perhaps his patients from disaster. The Auxiliaries of our Academies of Medicine would be well advised to launch an educational program for this purpose.

Mike was not confronted.

Hope must be transmitted to the alcoholic beginning with the moment of confrontation and must be shared by those confronting and attending him. For a long time before he became aware, or was made aware, that he was out of control, the alcoholic was existing in a state of lonely, anxious, confused, and fearful isolation from which the only escape he knew was by way of the depressant drug, alcohol. Dimly aware of his chaotic life, he felt the pain of guilt, but the only way he could tolerate this was to exchange it for the paranoia of resentment by heaping blame on everyone and everything handy. To recognize the role of his drinking would mean he must abstain, and this he could not do. If he tried another way out, it was probably by suicide or by self-administration of some other depressant (easily and commonly done by physician alcoholics). If he asked for help, it was for relief of his agitated depression, and he spoke of past and current stresses and of the pressures of his work and his family life. He certainly did not tell the truth about his drinking, if indeed he was aware of the truth. And he drank again. He tried changing jobs, changing residence, even changing wives, but he could not see the necessity to change himself. And he continued to drink. And the chaos was compounded.

Now, it has been spelled out to him that he is a man out of control, and he is expected to stop drinking and to regain control. He is either angry, devastated, or, sometimes, grateful. He is uncertain and confused about what lies ahead, about what is meant by treatment, by recovery. Remember, he has been isolating himself in an oppressive sort of fantasy world. What is so clear to us about his chaotic life is not at all clear to him. If he has been thinking about his problems at all, it has been in terms of ridding himself of external pressures, not of changing himself. Now, he is faced with reality and the challenge to look at himself and to take responsibility for his reactions, his behavior. The notion that his abuse of alcohol and/or other drugs is an illness has probably not occurred to him before, and he may feel both frightened and relieved by it. Even the idea that others can and will help him may be perceived as a threat.

Little good will come of simply advising him to seek treatment. If he were capable of making good judgments and reliable decisions, it would not have been necessary to confront him. We must know that he can have a better life, we must know what proper treatment is, and we must know where it can be obtained. Then, we must take him there. Once there, willingly or by coercion, he has a chance for recovery — hope. Alcoholism is a treatable disease.

But Mike died.

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Physician Drug Addiction
A Challenge to Medical Educators

Maria A. Borsay, Ph.D.
Arnold M. Leff, M.D.

MEDICAL LITERATURE has recorded cases of physician drug addiction dating back to the last half of the 19th century. However, since the 1950s, medical journal articles dealing with the problem have multiplied manifold, reflecting increased incidence as well as rising concern of medical and paramedical professionals. Estimates of the incidence of drug addiction among physicians vary from 30 to 100 times that in the general population.[1] More exact statistics are not available, probably due to the heavy social and professional penalties attached to being a physician addict.

In 1973, the American Medical Association Council on Mental Health sponsored a conference dealing specifically with drug addiction among physicians. The major emphasis of the conference was on procedures for identifying and rehabilitating the sick physician. Prevention was discussed only in the form of a series of questions, which included: "Is it possible to make significant advances in prevention?" and "Is there more that can be done to foster and strengthen mentally healthy attitudes in medical students and young physicians?"[2]

A survey of the literature reveals that some of these questions, such as how to screen applicants to medical schools, surfaced as long as 20 years ago, while others were dealt with, in part, by studies in the social science field. The purpose of this article is not to reiterate the medical aspects of the problem of addiction in physicians. Rather, it is to point out those studies in the social science field that have a direct bearing on prevention.

There is little disagreement in the medical literature concerning the dynamics of drug addiction in physicians. Three factors appear to be essential: a "preaddictive personality," role strain associated with becoming or being a physician, and availability of drugs.

The preaddictive personality has unresolved dependency needs stemming from early childhood experiences, usually some real or perceived deprivation.[3-6] Any form of psychologic frustration, if unrelieved, produces psychic pain accompanied by feelings of inadequacy, helplessness, and depression. Inability to solve the problem produces tension, contributing further to a lowering of self-esteem. According to Pearson and Little, this produces "tense depression" and prepares a person for addiction.[3] Vaillant, et al found that physicians were more likely to exhibit the traits of dependency, pessimism, passivity, and self-doubt than their socioeconomically matched controls, and that feelings of inferiority were common.[4]

As far back as 20 years ago, psychiatrists and psychologists suggested the necessity of further study of screening procedures with regard to the nonintellectual characteristics of the medical school applicant.[7] The major concern was to correlate personality factors with scholastic achievement and to develop means by which intellectual achievement could be predicted. The focus is still the same today, although there is more concern about performance in the role of physician.

Empirical research suggests that there is strong correlation between life adjustment prior to medical school and the presence or absence of psychiatric illness in physicians. Physicians with the least stable childhoods appeared vulnerable to the stresses of the physician role. Hunter, et al point out that of the 18.3 percent of the medical students seeking psychiatric help, 40 percent had personality problems before entering medical school.[8]

Although the medical literature often names access to drugs the primary reason for addiction, in spite of availability, most physicians do not become addicts.[9-11] Pharmacists, who have easier access to drugs than physicians, seem to have a much lower addiction rate, although solid statistics are not available.[5,12] Alcohol is always available; and indeed, drugs often are used by physicians for the first time to relieve a "hangover"[13] or because excessive drinking becomes too noticeable.[14] It seems that access to drugs more often determines the type of drug a physician will use rather than whether or not the physician will become an addict. For example, a large percentage of physician addicts use meperidine (Demerol®) as opposed to the street addict who is addicted mostly to heroin.

Although the "preaddictive personality" and access to drugs appear to be important factors, they alone do not cause addiction: stress is a necessary ingredient. Overwork, chronic fatigue, and physical disease are the three classic reasons given by physicians for taking a drug for the first time.[5] They also mention impact of work on family life (most physician addicts have unstable marriages[1]), night calls, emergencies, and treatment failures. Most authorities consider overwork a symptom of addic-

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tion rather than a cause.[4,5,9,15] It is a mechanism of retreat from overwhelming personal conflict, and one of several responses an individual can make to strain.

The social science literature reveals examples of how stress can be produced in the environment of the medical school and, as a result, in future practice.[16,17] Of course, students show great individual variation in their responses to stress and tolerance of anxiety, as do medical schools in confronting their students with stressful situations. However, social scientists are primarily concerned with those aspects of the environment which produce stress for all students or groups of students rather than individuals.

It is not possible to completely analyze stress situations in medical schools in this brief article. We have selected only a few examples in the hope that these might illustrate the problem and encourage medical educators to view the operation of a medical school from the viewpoint of student response.

One of the most complete studies of medical school culture was done by Becker, et al about 20 years ago, which still appears applicable.[16] As an overall approach, the study describes a "student culture" which is designed to find collective solutions to problem situations as defined by the students. The goal is to reduce stress and to make the environment manageable. The following examples from that book will serve to illustrate some of these stress situations.

In the first year, the most pressing problem faced by students is "overload," the tremendous amount of material that must be learned. Since there is more work to be done than students can do in the time available, they must decide what and how much to study. At first, the students try to "learn everything." One student in the study attempted to deal with the problem by memorizing everything because it took less time than thinking.

When learning everything is seen as not feasible, students develop another perspective: "What the faculty wants us to know." To find out what the faculty wants also is a difficult task and often brings student and faculty perspectives in conflict.

Students then solve the overload problem by relying on textbooks and lectures as the most effective and economical way to learn. On the whole, faculty members oppose this as well as memorizing. By using this method of learning, students develop a reputation of being uninterested in research and theory and only being interested in facts.

Lack of consistent faculty philosophy with regard to teaching (spoonfeeding versus self-direction) contributes to the development of student perspectives because they must solve the overload problem themselves. Such solutions frequently are unsatisfactory to the faculty, adding to student stress. Faculty might alleviate some of the strain by agreeing to a more consistent teaching philosophy, as well as by being more specific in communicating their expectations to the students.

Stress continues as the student progresses toward graduation from medical school. Although examination pressure decreases in years three and four, students still must select what to learn from the mass of clinical experiences that confront them. Faculty members probably would agree that students in the clinical years should learn to observe and then to reason their way to the best possible diagnosis. In this manner, students could master the basics of scientific medicine and skills involved in interacting with patients.

However, because students are often not afforded opportunities for responsibilities (due to their low position on the "medical totem pole") and do not feel free to express discontent with the clinical training situation, stress arises. In this example, as in the previous one, such stress could be reduced by more effective faculty-student communication.

There are many other areas of disagreement in perspectives between faculty and students, such as the nature and purpose of medical education, the role of the resident in teaching, and what constitutes the "serious" approach to work in medical schools. The results of research with regard to the value of psychologic tests in predicting medical school grades have not been impressive. Premedical grades or the Medical College Aptitude Test appear to be far better indicators.[12] A survey of medical school entrance requirements reveals that only a handful of schools even attempt to identify personality factors through objective testing methods. Most rely on personal interviews, often conducted by unqualified members of an admissions committee. The literature often mentions cost as well as technical problems as reasons for inadequate personality testing of medical students. In the long run, it appears that the cost of training a physician who will not practice more than five to ten years as well as the cost of his treatment and rehabilitation from addiction would far outweigh the cost of more adequate screening procedures.

Problems of conflicting norms and expectations also apply to interns and residents. They work with a teaching staff that may have different values and goals. Conflicts arising from these differing viewpoints can produce a great deal of stress.[17]

Finally, the type of a physician's practice also contributes to the amount of stress he experiences. There is consensus in the literature that most physician-drug addicts are private practitioners as opposed to institutional employees or members of some form of group practice.[5,18] Although private practice places a great deal of strain on physicians, medical students do not seem aware of this fact.[17] They need to understand the alternatives available to them in both the type of practice and how the practice is handled. Reduction in willingness to make house calls (to some extent brought on by technology improvements) as well as increases in salaried positions and group practice serve as adjustive mechanisms, although many of the family practitioners who complain about fatigue and overwork are not willing to "share" their patients.

In review, the three essential ingredients of drug addiction are personality factors, availability of drugs, and stress. There is a need for more research to develop better

screening techniques for identifying nonintellectual characteristics of medical school applicants. Better screening may reduce the potential number of addicts in the physician population. In addition, medical educators must take a closer look at reducing stress situations in medical education. Such a reduction in both medical education and later practice should lessen the number of physicians who turn to drugs for relief from pressure. As Merton points out: "Behavior is not merely a result of the individual's personal qualities but a resultant of these in interaction with the patterned situations in which the individual behaves."[19]

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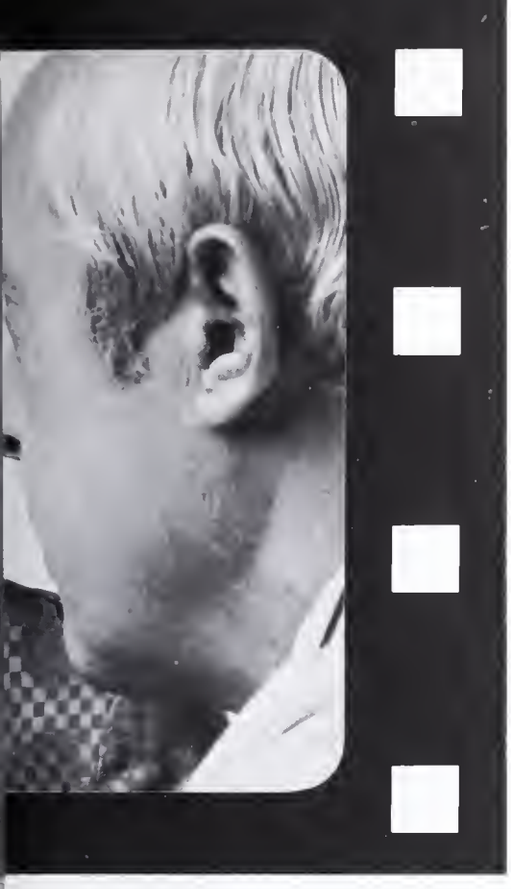
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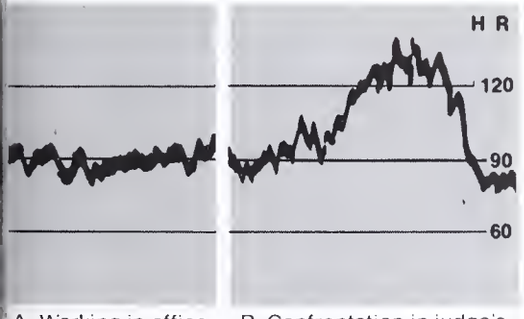
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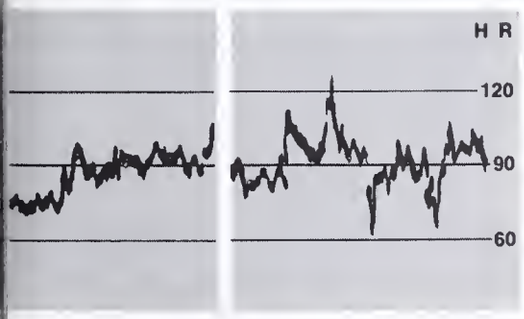
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Mental Disorders Among Physicians

E. Richard Dorsey, M.D.

WHILE MUCH PUBLIC AND professional attention has focused on the problems of alcoholism and drug abuse among physicians, members of the medical profession are susceptible to a number of other mental disorders as well. Alcoholism itself may be a primary illness, or it may be a symptom of some other mental condition.

The Physician Effectiveness Program of the Ohio State Medical Association deals primarily with colleagues whose mental impairment significantly interferes with professional performance. Other than abuse of alcohol and drugs, the three most common mental disorders associated with severe disability are depression, organic brain syndrome, and schizophrenia.

Depression

Depression comprises a number of syndromes, including those currently diagnosed as depressive neurosis, manic-depressive illness, involutional melancholia, and psychotic depressive reaction. Depression frequently is a recurrent disorder, with the first episode usually occurring after the age of 30 years. Some syndromes seem to have a major genetic component, with an associated disturbance in neurophysiology.

Psychologic symptoms include despondency, anhedonia, anxiety, impaired concentration, and difficulty with memory. Physiologic symptoms include sleep disturbance (particularly insomnia with early morning awakening), changes in appetite (especially anorexia and weight loss), anergia, fatigue, and a vague sense of malaise. Cardiovascular changes, including palpitations, air hunger, and alterations in blood pressure can occur. Altered bowel function is also common.

Severity, presence of physiologic disturbance, and persistence of symptoms over several months distinguish the illness of depression from transient mood fluctuations. Some depressions seem to relate to particular life events, while others appear to have a spontaneous onset. For a few individuals, periods of despondency alternate with elation, excessive energy, grandiosity, and impaired judgment, leading to a diagnosis of bipolar manic-depressive illness.

In addition to impaired professional performance, the chief hazard associated with depression in physicians is suicide. Like other depressed individuals, physicians are ambivalent about taking their own lives, even at the time they make an attempt. However, physicians usually have a clearer understanding of lethal drug doses, and of other means of assured self-destruction, and thus may be more likely to succeed in killing themselves.

Depression-induced suicide is a particularly tragic form of death since most depressive disorders ultimately remit spontaneously. In addition, currently available treatment can reduce the morbidity and relapse rate of depression promptly and predictably.

For moderate-to-severe depression associated with physiologic symptoms, tricyclic antidepressants are generally considered the drugs of choice. Dosage requirements vary widely, based primarily on genetically inherited differences in metabolic rate. About 70 percent of patients respond to daily oral doses of 250 to 300 mg of amitriptyline, desipramine, imipramine, or nortriptyline. The placebo response rate in this group is 40 percent to 50 percent with the difference being highly significant both statistically and clinically. Where oral dosage is adjusted to provide a plasma level of any of these medications in the 100 to 200 microgram/liter range, a response rate approaching 90 percent can be obtained.

In addition, psychotherapy often is indicated for purposes ranging from counteraction of demoralization to change in behavioral patterns and interpersonal relations. Drug therapy and psychotherapy have been shown to have an additive effect, with medication providing symptom relief, while psychotherapy improves social functioning.

Organic Brain Syndrome

The most common organic brain syndrome among physicians, as among the general population, is that associated with aging. The effects of senile brain disease and cerebral arteriosclerosis are somewhat difficult to distinguish clinically, both being manifest by impairments of intellect, judgment, memory, and behavior. Age of onset is variable, with the first overt manifestations usually appearing between the ages of 60 and 80 years. The course of the disorder is also variable, with some patients experiencing minimal progression over a decade or more, while others deteriorate rapidly.

The associated mental impairment can markedly reduce a physician's capacity for competent, independent practice. Some doctors recognize their limitations and voluntarily curtail their activities by treating only patients

(continued on page 748)

Dr. Dorsey, Cincinnati, is in the private practice of psychiatry.

Reprint requests to 7913 Euclid Avenue, Cincinnati, Ohio 45243 (Dr. Dorsey).

Submitted July 8, 1977.

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*National Disease & Therapeutic Index, Jan.-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976
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whom they have known for years, discontinuing hospital practice, and routinely referring difficult cases to colleagues. Unfortunately, others fail to recognize or acknowledge their decline and insist that their professional abilities remain undiminished.

Depression and organic brain syndrome often coexist, with each tending to exacerbate the other. Depression in the elderly can result in weight loss, social withdrawal, inattention to personal hygiene, and impaired memory, concentration, and cognition. Conversely, the reduced memory and intellectual capacity associated with organic brain syndrome, and consequent impairment of professional and social functioning, can lead to or exacerbate depression.

Effective treatment of the depression associated with organic brain syndrome is similar to that already described. Older people generally require substantially lower doses of tricyclic antidepressants than younger adults, due to differences in metabolic rate and central nervous system (CNS) sensitivity. However, wide inter-individual variability exists in this age group as well, and dosage must be carefully individualized. Improvement in "organic" symptomatology often accompanies resolution of depression.

Hydrogenated ergot alkaloids have been shown to relieve various symptoms associated with organic brain syndrome in some elderly patients. The degree of improvement is difficult to predict, and the exact mechanism of action is unknown. Changes of cerebral circulation, metabolic alterations, and mild antidepressant activity have all been postulated.

Psychotherapy can be helpful both in counteracting demoralization and social isolation, and facilitating a reasonable understanding of the degree of impairment. Periods of denial of impairment may alternate with unwarranted pessimism, hopelessness, and self-depreciation.

While treatment usually results in considerable improvement, the prognosis for independent medical practice is doubtful. In these instances, a difficult dilemma faces both the individual physician and the medical profession.

On the one hand, the medical profession has an obligation to protect the public from incompetent medical practice, even by physicians with many previous years of distinguished professional service. However, the loyalty of former patients, the absence of ready alternative sources of care in our smaller communities, and the fluctuating degree of impairment due to organic brain syndrome combine to make the decision to press for complete termination of practice entirely a difficult one.

Similarly, the conscientious physician may be aware of his own impairment, and have no desire to jeopardize his patients. He may also have seen other physicians of his own or previous generations whose performance in their last few years tarnished reputations based on decades of highly competent practice. On the other hand, many of his patients may prefer to remain under his care, particularly for conditions whose management depends at least as much on the rapport between doctor and patient as on technical knowledge and judgment. Finally, physicians as a group are hard-working people whose professional acivities occupy the central position in their lives; cessation of practice means loss of their professional identity, their sense of purpose, and the gratification of providing needed services.

Schizophrenia

Schizophrenia occurs relatively infrequently among physicians, and, unlike depression and organic brain syndrome, has a lower incidence in the medical profession than in the general population. This disorder occurs more frequently in the lower socioeconomic groups of society, whereas physicians occupy and are drawn primarily from the middle and upper classes. Perhaps more important, the first episode of schizophrenia usually occurs between the late teens and late 20s, often effectively barring those afflicted from a medical career.

Moderate-to-severe impairment of thinking, affect, and social functioning characterize schizophrenia. Classical stigmata of insanity, such as hallucinations, delusions, and paranoia are present frequently.

Available evidence indicates that genetic factors play a major role in the disturbance of the neurotransmitter, dopamine, that seems to underlie this disorder. The role of environmental factors, particularly stress, in precipatating a schizophrenic episode, is somewhat less clear. Drug and chemical abuse also may be related to schizophrenia, but whether on a correlational or casual basis is difficult to establish.

At least two subtypes of schizophrenia have long been recognized on the basis of onset and clinical course. Acute episodes occurring in individuals with relatively normal premorbid functioning, and associated temporally with major environmental stress, seem to have a much better prognosis than ones with an insidious onset in people who were peculiar, isolated, or withdrawn even before the illness began. A few of the former may experience only a single episode in lifetime, with complete recovery. More typically, several episodes can be expected, though modern pharmacotherapy has a high degree of efficacy in producing and maintaining remission.

The antipsychotic drugs are generally an essential, though not fully sufficient, component of the treatment regimen for schizophrenia. Their efficacy in relieving the positive symptoms of psychosis and thought disorder, and in maintaining remission, approaches that of insulin for diabetes mellitus. Some form of psychotherapy usually is necessary to counteract social isolation, improve interpersonal functioning, and foster an understanding of the nature of the disorder and how the individual can adapt to it. Good rapport between physician and patient also seems necessary to assure compliance with a maintenance medication regimen, which poses at least as great a problem in schizophrenia as in hypertension.

When schizophrenia afflicts a member of the medical profession, it usually appears first during the student or housestaff years. Relapses may occur at later periods of

life, but proper treatment should minimize the incidence and severity of such recurrences. Overt psychosis clearly precludes satisfactory professional performance. A physician with schizophrenia in complete remission may practice competently. Where residual disability exists, individualized judgment is necessary regarding the need for supervised practice, or the physician's lack of capacity for patient care responsibility in any form.

Adjustment Disorders

In addition to the illnesses described herein, which often have major impact on professional competence, a number of more common disorders can cause mild-to-moderate impairment of professional and interpersonal functioning. Such cases rarely come to the attention of the Physician Effectiveness Program, but are generally apparent at the hospital staff and medical community levels.

Marital Maladjustment

Physicians, as a group, are industrious people and tend to be absorbed in their work. They also are inclined to set very high standards for themselves and for those around them. In their professional role, they are used to authority and deference, and to making major decisions whose execution is often delegated to others. Their social status is high, and their role in the community generally is well-established.

Marital problems commonly arise from several sources. Simple lack of distraction-free time together can strain any marriage. Husbands absorbed in stimulating work often grow estranged from wives whose activities focus on household and children. Men who have been working for 10 to 12 hours want to relax when they get home, while women who have been confined to the house for the same time period want to get out and socialize with other adults. Dealing with a leaky roof or a misbehaving child may seem trivial and irritating after a day of "life-and-death decisions."

Finally, depression can cause marital difficulty due to the individual's irritability, despondency, pessimism, and anhedonia. A previously satisfactory marriage can seem disagreeable to a depressed individual, and conversely, marital stress can precipitate depression.

Short-term psychotherapy can be helpful in improving understanding between the physician and his spouse. The importance of spending time together and sharing domestic responsibilities can be stressed out. The inclination of physicians to over-extend themselves, and to take on unnecessary professional responsibilities can be countered, as can the tendency to substitute material gifts to the wife for personal attention. This last practice is particularly pernicious since it is commonly used to justify (and can, in fact, necessitate) the physician's working even harder.

Mid-Career Restlessness

At some point in the fifth decade of life, many physicians begin to wonder about another 20 years of the same activity. Such a phenomenon seems more common among private practitioners, whose professional activities involve somewhat less variety, innovation, and advancement than academia or administration. Existential questions about the meaning of life, work, and family also may arise at this time and overlap with marital dissatisfaction.

Informal consultation with colleagues is frequent, particularly with those engaged in different kinds of professional activities, or those who have left private practice and subsequently returned. Generally, the physician will adopt one of three courses.

First, after some period of reassessment, he may decide that his present course is most suitable for him and pursue it with renewed enthusiasm. Second, he may continue the same basic activity, but introduce one or more variants. For example, he may concentrate on the kinds of patients or disorders in which he has the strongest interest and curtail his commitment to others. Conversely, he may expand into a new area, or accept part-time work in administration, industrial medicine, or public health.

Finally, the physician may conclude that time has indeed come for a change, and terminate his practice to accept a salaried clinical or administrative position. Or, he may elect to re-train in a new specialty, with anesthesiology, pathology, psychiatry, and radiology being favored particularly.

Summary

The OSMA Physician Effectiveness Program deals with physicians suffering from a variety of disorders, and does not focus exclusively on alcoholism and drug abuse. The conditions most likely to come to OSMA attention are those associated with significant impairment of professional functioning, which include depression, organic brain syndrome, and schizophrenia. In addition, adjustment disorders with limited impact on medical practice are common, including marital maladjustment and mid-career restlessness.

The OSMA Program offers assistance to the disabled physician on his own request or that of other responsible individuals. It also serves the public interest by providing an expeditious, informal alternative to action by the Medical Licensing Board.

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Alcoholism

Reflections and Reproofs

Charles N. Hoyt, M.D.

A Look Backward

SEVEN YEARS AGO, a handful of pioneering souls, with the encouragement of the editor, devoted the July and August 1970 issues of *The Ohio State Medical Journal* to the subject of alcoholism. Although there were no Nobel awards forthcoming, the effort was laudable and one of the many milestones of progress in the field of alcoholism. Still another step forward is the publication of this issue for which the editorial staff and the authors deserve accolades. It's been "open season" on the physician for too many years; and I don't have to remind anyone of the attempt by the news media, the bureaucrats, and the planners to picture us as less than professional. This issue of *The Journal* is testimony to the fact that at least one of the professions is "cleaning up its act."

Although the Ohio Physician Effectiveness Program is geared to help the doctor disabled from any one of a number of causes, drugs and alcohol remain the principal etiologic agents. Comments by this author will be confined to alcohol and its abuse.

Slow Progress

Progress in the study and treatment of alcoholism has been slow. A complex interplay of a number of factors is responsible. It has only been within the past decade that alcoholism has become an acceptable household word, and that the opprobrious epithets assigned to it have been dropped. The effects of the Temperance Movement on our drinking have progressively become less burdensome and less guilt-producing. Inexorably, the ambivalent feelings of our society about beverage alcohol have dissipated and a love affair with it has ensued.

We are a drinking nation with approximately 60 percent* of the adult population (18 years of age and older) drinking regularly.[1] We are a country psychologically dependent on alcohol, its people increasingly in need of a communication and recreational catalyst. It follows that an organized interest in complications of alcohol abuse would not be met with enthusiasm. But the eventual pronouncements by the American Medical Association, the American Hospital Association, the American Psychiatric Association, and later, the American College of Physicians that alcoholism was a disease served to promote a formalized approach to drinking problems. This interest became a tidal wave of activity with the creation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) by the federal government in 1970. Regrettably, cores of resistance to the "illness concept" remain, with a minority of social scientists, behavioralists, mental health specialists, and moralizing physicians finding it "controversial."

The most formidable roadblock to progress, however, has been set up by the liquor industry itself. Alcohol is big business! It has been stated that the licensed beverage industry is second only to the automotive industry in the amount it contributes to U. S. economy. In 1973, there were 183 million gallons of distilled spirits, 292 million gallons of wine, and 4.6 billion gallons of beer produced in the United States.[1] That year, for each person over 15 years of age, 2.61 gallons of distilled spirits, 2.25 gallons of wine, and 27.5 gallons of beer was the apparent average consumption.[1] In 1971, total alcohol revenues for federal, state, and local governments amounted to $7.9 billion;[2] this figure has now risen to more than $9 billion. It is clear to see that some arms of the government automatically become an ally of the licensed beverage people in their opposition to incriminating the substance alcohol in the production of a disease process.

However, when one looks at the cost to society of alcohol abuse, the books aren't balanced. A recent study, made for the National Institute on Drug Abuse (NIDA), estimated the cost at $32 billion for the year 1975. This figure includes lost production, health and medical expenses, motor vehicle accidents, alcohol and research programs, and criminal justice system costs. Although an increase in the level of alcohol taxation has been considered repeatedly, there has been a moratorium on it for some time. This helps the brewers, the vintners, and the distillers to hold their prices considerably below the relative prices on the consumer price index (CPI). As it now stands, it is relatively cheaper to buy beverage alcohol than food.

Employing the hackneyed expression that "alcohol does not cause alcoholism," the Distilled Spirits Council of the U.S. (DISCUS), the public relations arm of the liquor industry, has vocally defended its position of assuming little responsibility for the havoc that is transpiring.

Dr. Hoyt, Columbus, Medical Director, Alcoholism Services Department, Riverside Methodist Hospital; and Clinical Instructor, Preventive Medicine, The Ohio State University College of Medicine.

*Gallup pollsters now say the percentage has risen to 71 percent with most of the new drinkers being women.

The Root of All Evil

I am sure that some of us have compared the history of the United States with that of the Roman Empire, and that the more pessimistic of us envision a progressive change for the worse in our way of life. Some suspect that wine had its role in the fall of that great empire of the past, and others are convinced that beverage alcohol is contributing to this nation's deterioration. But comparisons are odious and emotionally laden impressions are not "statistically significant." And yet when we witness the development and promotion of various flavored, 30-proof "milkshakes" (without formal protest until recently) by the liquor industry, with the youth market clearly the target, then there is indeed something "sick" about our society. The advertisements for these 30-proof shakes featured youths holding bottles of "kickers," and to supplement the advertising, T shirts, jean patches (a kicker in the pants), and wall posters were offered.

By coming in at 30 proof, alcohol milkshakes qualify for supermarket sales in many states. There are 32.8 million youth in the 12-to-19-years age group in this country. It is irrational to think that the liquor industry would spend some $500 million per year in advertising without knowing the impact of its ads on individuals in society.

So much for national "schizophrenia" and "progress." Advances come slowly in medicine, and the problem of alcoholism is no exception. Even slower is the evolutionary process involved in the development of the thinking brain of Homo sapiens.

The Drug Itself

As the old expression goes, if alcohol were invented today, it would be a best seller tomorrow and banned by the FDA the following day. Ethyl alcohol is indeed a remarkable drug with all manner of magic, mystic, and divine qualities ascribed to it since its "invention," in the form of wine, some 5000 years ago. That beverage alcohol has become as much a part of man's life and living as food is a matter of history. It has figured prominently in the molding of this nation, from the days of the heavy-drinking Puritans to the present. The first taxes on alcohol helped to support the Civil War, and the winning of the West found the ability to "hold one's likker" equated with masculinity. Good or bad, alcohol has been a catalytic agent in many high-level national and international conferences. Grant may have won a battle or two because of it, and other less famous figures, while under its influence, created such ablution scenarios as to make them notorious in the news media. Allegedly, some literary giants might well have been less creative without the use of ethanol.

However, in spite of its glamour, alcohol is one of the most toxic of all drugs and certainly is "dangerous to your health." Yet we in this country can't seem to afford to have that label appear on a bottle anymore than the economy of the nation — and the thirst of its inhabitants — can afford to have a "stuffer" come with each purchase. Nonetheless, there are hints of change. Legislative efforts to effect more honest advertising by the liquor industry are being considered, and the day may come yet when the side-effects of ethanol abuse are made known to the drinking public by the distillers and brewers.

Product Information Insert

For some time, the lay literature has contained numerous articles on alcoholism and the medical complications of alcohol abuse. Friends and patients are asking about cirrhosis, "wet brain," and alcoholic heart disease. Perhaps it is time for the distillers and brewers to consider a circular, in compliance with FDA regulations, containing a comprehensive description of beverage alcohol. A supplement to *Physicians' Desk Reference* (PDR) then might read as follows:

> ALCOHOL, ETHYL
> (Manufacturers' and brand names too numerous to list)
> Formerly Elixer of Life; Spiritus Fermenti
>
> **Description:** Ethanol, a monohydric alcohol, is a clear colorless liquid formed through fermentation of a variety of products as grain, potato mashes, fruit juices, and beet and cane sugar molasses. Preparation of pure ethanol involves distillation. The same product for industrial use also can be obtained by a procedure of synthesis.
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> **Actions:** A unique drug; may be regarded as a psychotropic agent, a sedative, an anesthetic, a rubifacient, a bactericidal compound, and a food stuff. The physiological and biochemical action of ethanol on the tissues and cells of the organism can be divided into two distinct groups, the first including the direct and indirect consequences of alcohol metabolism which are seen at low ethanol concentrations and the second summarized as the pharmacologic actions of alcohol, much less specific and independent of the metabolism of alcohol itself; said actions become manifest at high concentrations of alcohol.
>
> Alcohol is soluble in water in all proportions, which facilitates its rapid distribution throughout body water by simple diffusion. There is no evidence that it is bound or stored. The major, if not the only, site of ethanol metabolism is the liver, where the metabolism proceeds at a constant rate independent of any homeostatic control mechanisms. It is transferred in two metabolic steps to acetate, one of the major precursors of the Krebs cycle.
>
> Unlike other drugs, alcohol has a high caloric value: 7.1 calories per gram. A pint of 86-proof spirits represents about half the daily caloric requirements. However, ethanol calories are "empty calories," being unassociated with proteins, minerals, and vitamins.
>
> **Indications:** The oral route is preferable. Traditionally a ritualistic or ceremonial substance, its social use is deteriorating into neurotic and habitual patterns of abuse. Therapeutically, it has limited value. Any other discussion is outside the scope of this "circular," other than to mention that alcohol has become the favorite mood-altering drug of almost every human society.
>
> **Warnings:** May be habit-forming. Alcoholism may result from extended and extensive use. For poorly understood reasons, about one out of ten drinkers becomes an alcoholic due to a complicated interplay of physiologic, sociologic, and psychologic factors which finds the individual experiencing (A) an increasing tissue tolerance; (B) an adaptive cell metabolism; (C) eventual withdrawal symptoms upon discontinuance of alcohol; and (D) the loss

of control or "craving" phenomenon once drinking is resumed. Most authorities accept the illness concept[3] and do not subscribe to a somewhat outmoded psychiatric theory that alcoholism is "symptomatic of something else." The majority of alcoholics at the onset of their drinking careers are no more psychologically vulnerable than their drinking peers.

There are approximately ten million alcoholics in the United States, with another ten million "on the way." Were the alcoholic his own victim exclusively, the dilemma might be less acute. But for every alcoholic, there are 2½ to 3 other lives involved; thus, the tangled web of alcoholism ensnares countless millions of relatively innocent "bystanders." Alcoholism can be a catalyst for violence of all types. Statistics reveal that there are at least 100,000 alcohol-related deaths in the U.S. each year. The human price is not confined to unnatural death. The medical and surgical wards of general hospitals, depending on locale, may show 25 percent to 35 percent of the patient population, regardless of diagnoses, to have alcohol complications.[4]

Usage in Pregnancy: The fetal alcohol syndrome has been redefined recently by a group of Seattle investigators.[5,6] In May 1977, the National Council on Alcoholism issued a warning to women that drinking alcohol during pregnancy increases the chance of birth defects, physical and mental. Considerable research is currently in progress concerning the effects of maternal alcohol consumption during pregnancy on subsequent behavioral consequences in the offspring. It is recommended that expectant mothers consult their physicians about the use of beverage alcohol during pregnancy.

Precautions: Contributing to the magnitude of the alcoholism problem is the failure of many physicians to recognize the existence of multiple drug abuse. Alcohol interacts with many clinically prescribed drugs, among them antibiotics, anticoagulants, and psychoactive drugs. The sedative-hypnotic drugs produce with alcohol either synergistic or additive effects with eventual evolvement of a cross tolerance-cross dependency phenomenon between alcohol and said drugs. This list includes chloral hydrate, paraldehyde, meprobamate, the barbituates, glutethimide, methylquaalude, and possibly propoxyphene. The so-called minor tranquilizers, principally the benzodiazepene class of sedatives, have been added to the list. Unfortunately, an increasing incidence of diazepam dependency is being encountered, particularly in the heavy drinking community. It behooves both the physician and pharmacist to maintain a high index of suspicion — and wisdom — where the heavy-drinking patient and/or alcoholic is concerned.

Adverse Reactions: Medical complications related to the ingestion of large amounts of beverage alcohol are being identified with increasing frequency. All too often, these complications, send the patient to the physician with said patient, nonetheless, frequently denying excessive drinking. The modern physician must develop skills not only to treat the organ pathology of the alcohol abuser, but to recognize the underlying process. If in doubt about his expertise in diagnosing alcoholism, the physician should be aware of the many clues offered by the pathophysiology and the distinct disease states seen in the heavy drinker.

No organ or system in the body escapes the effects of prolonged ethanol excess. Prior to the development of various disease entities, chronic alcohol exposure results in profound biochemical and morphological changes. Alcohol inhibits gluconeogenesis and can lead to hypoglycemia if there is a substantial depletion of liver glycogen. Alcohol inhibits the synthesis of albumin and other specific proteins as transferrin and complement. Deficiency of the latter would appear to contribute to the increased susceptibility of the alcoholic to infection.[7]

Prolonged alcohol abuse results in hypertriglyceridemia and fatty liver. That the steatosis is the first stage in the continuum of alcoholic liver disease is generally accepted today. That a transition from fatty liver to alcoholic hepatitis and cirrhosis takes place in the heavy drinker (and alcoholic) remains an issue of dispute. However, there has been much sophisticated research supporting the "transition," and the malnutrition theory of cirrhosis would appear to be outmoded. These subjects, with extensive references, are covered in *Metabolic Aspects of Alcoholism,* edited by C.S. Lieber (University Press 1977) and *Medical Consequences of Alcoholism,* edited by Siexas, Williams and Eggleston (N.Y. Academy of Sciences 1975). Alcohol has its effect on the rest of the gastrointestinal system. The commonest cause of chronic pancreatitis, at least in North and South America, is alcohol abuse.[8] Gastritis is very common, and malabsorption of a number of substances including folic acid and vitamin B_{12} is seen in alcoholics with poor dietary habits.

Not given enough attention in our drinking society is the effects of alcohol on the cardiovasular system. For reasons poorly understood and not reflecting the abstinence syndrome, alcohol abuse is a common cause of hypertension. Klatsky's work at Kaiser-Permanente (*N Engl J Med* 296: 1194-1200, 1977) is awakening interest in this relatively unresearched phenomenon. The direct toxic effect of alcohol on heart muscle has been described by a number of investigators, and primary alcoholic heart disease is an acceptable diagnosis. The heavy drinker is prone also to develop conductive heart disturbances with arrhythmias related to electrolyte and mineral imbalance. The *Medical Consequences of Alcoholism* referred to previously (pp 235-272) reviews the subjects concisely.

The skin and musculoskeletal systems do not escape the effects of ethanol excess. Aside from the sequelae of alcohol intoxication, the concurrent skin changes in alcoholic liver disease are easily recognized. A number of dermatoses are alcohol related or aggravated; the list would include seborrheic dermatitis, acne rosacea, acne vulgaris, black hairy tongue, neurodermatitis, and various eczemas. Alcoholic myopathy and aseptic necrosis of the femoral head lead the list of diseases (excluding trauma) of the musculoskeletal system seen in alcoholics.

The hematologic changes seen in chronic alcohol abuse are many. A kaleidoscopic variety of complications occur making it difficult to disentangle the relative roles of liver disease, malnutrition, infection, impairment of iron and folate metabolism, and bone marrow suppression. Various types of anemia, as well as leukopenia and thrombocytopenia, are frequently encountered in the alcoholic. Progress in delineating the significance of ethanol itself as a hematologic toxin and the current state of knowledge is covered by Lindenbaum in *Metabolic Aspects of Alcoholism* (pp 215-247).

The effects of alcohol on the nervous system are as multiple and complex as our knowledge of brain function is limited. A constellation of behavioral, neurochemical, neurophysiologic, psychologic, and pathologic alterations and problems result from alcohol use and abuse. In ascending order and dose dependent, alcohol in man can bring about intoxication, stupor, coma, and death. Woven into this sequence for the alcoholic is the mechanism of tolerance and progressive physiologic dependency. Memory blackouts or alcoholic amnesia are encountered in the habitually excessive drinker, particularly those destined to become alcoholic.

Prolonged ethanol excess results in alcohol addiction and its concomitant, the alcohol withdrawal syndrome. The continuum of this latter pathologic state ranges from tremulousness or "the shakes" (with increasing

autonomic overactivity) through hallucinatory experiences and "rum fits" to delirium tremens, which if untreated, carries with it a mortality rate of nearly 15 percent. Again, these poorly understood phenomena seem to be dose and time (ie, years of drinking) related, but it is suspected that genetically determined individual biologic variations also play a role. A number of neurologic diseases are seen in the chronic alcoholic, some representing nutritional deficiencies. The list includes alcoholic polyneuropathy, Wernicke's encephalopathy, Korsakoff's psychosis, alcoholic cerebellar degeneration, Marchiafava-Bignami syndrome, central pontine myelinolysis, alcoholic cerebral atrophy, and alcoholic hepatic encephalopathy.

Our knowledge of how and where ethanol acts in the central nervous system is rudimentary. It has been known for some time that alcohol depresses by a primary direct action on the excitable membrane.[9] The changes of behavior produced by ethyl alcohol arise as a result of the effect of alcohol or its metabolic products on the biochemical processes occurring in the brain. The neurotransmitter systems have received much attention recently. Evidence has shown that certain biogenic amines influence behavior. The ability of certain plants to synthesize alkaloids has long since resulted in several hypotheses invoking the possible endogenous formation of aberrant amine metabolites and/or alkaloids in man to explain psychiatric illness. The possible endogenous formation of alkaloids as a concomitant of alcoholism has been postulated by several investigators. Davis and her coworkers[10] propose that mammals including humans, following ethanol administration, are capable of forming complex alkaloids with pharmacologic properties including addictive liability. The search for a biochemical "lesion" in alcoholism continues.

Physician, Heal Thyself

It has all been said before in countless numbers of ways and by numerous authors, some sympathetic and benevolent, some vindicative and blasphemous. The physician, traditionally the great healer and the symbol of strength, is not immune to stress. His profession calls for intellectual and moral capacities of a high order. He must accept frustration and defer satisfaction with resiliency. His code has been service above self. The challenge that this model presents is tremendous and carries with it a significant morbidity rate.

Although the physician collectively may have damaged his own reputation, the iconoclasts and the muckrakers have so chipped away at him that the conventional image is but a skeleton of its former self. The physician is no longer a hero!

But another phenomenon is taking place that finds the doctor in a position that is frustrating and ill-defined. Not only is his rank as leader of the health team being challenged by a horde of health-oriented, self-styled "experts," but he is losing a support system. As we have become a transient country, we are losing contact with family, with other institutions, and with a well-defined and identifiable group of patients that we called our "practice." This group today is open-ended with a constant flow of people through it. We now deal with an impersonal volume rather than a predictable contingent with a personality of its own. Our loyal supporters of the past do not exist as an entity today. We no longer have a cheering section!

The modern physician is in a more precarious state and is more vulnerable than at any time in history. His strengths and weaknesses are being tested by a society in the throes of a total psychologic malaise. By virtue of training and an intact, internalized value system, the physician is in a position from which he can emerge unimpaired — or he can succumb to the pressing desire of man to feel better, to feel different — by the use of chemicals.

Doctor, apply *primum non nocere* to thyself.

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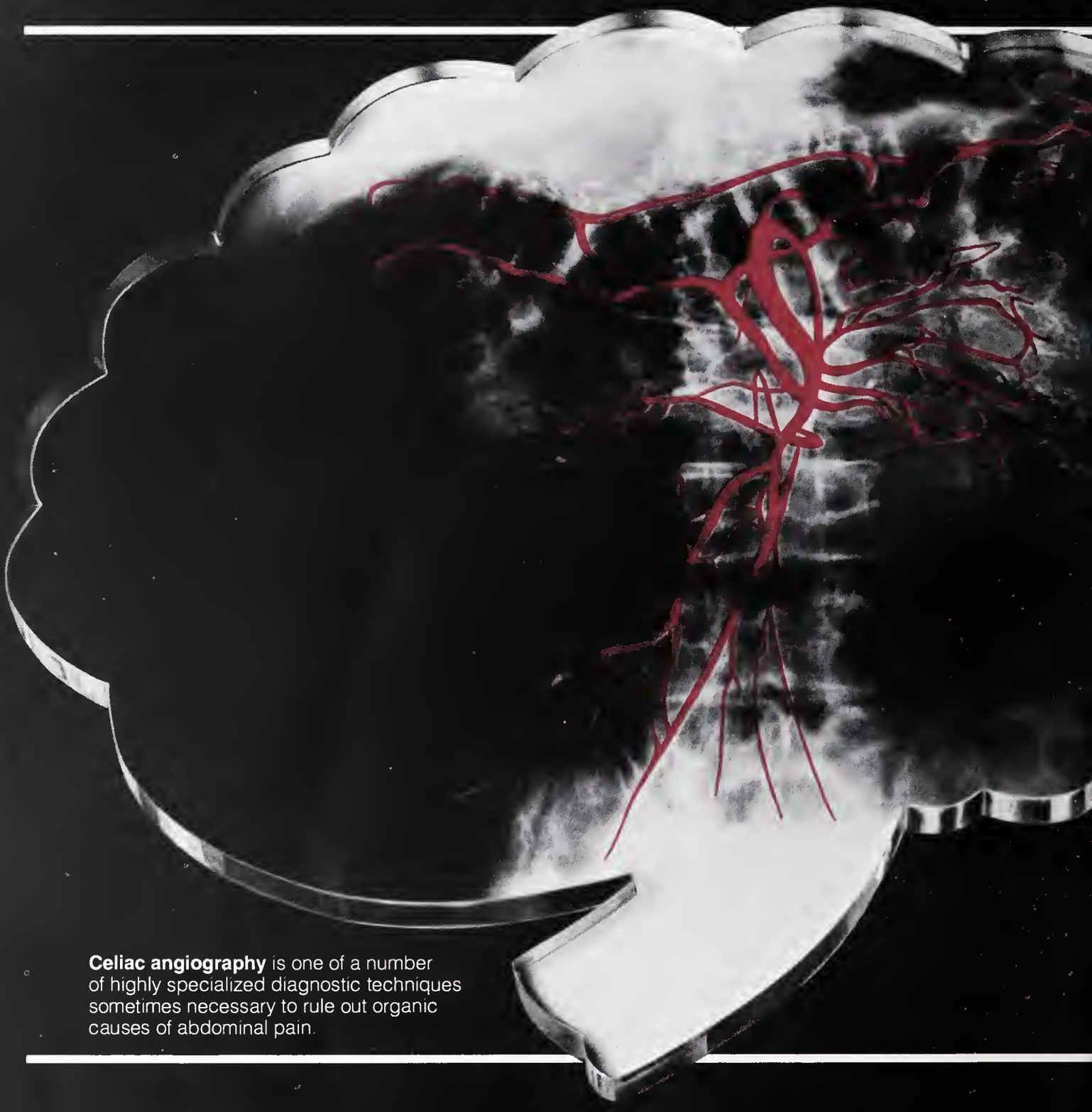
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Medical Management of Narcotic-Addicted Physicians: A Practical Review

Arnold M. Leff, M.D.

IN DISCUSSING THE narcotic-addicted physician, it must be pointed out that some obvious, unique characteristics affect treatment. In spite of legal and bureaucratic obstacles, the addicted physician has virtually unrestricted access to an unlimited array of narcotic and similar drugs and is "professionally" knowledgeable about their use. In addition, the addicted physician often is very sophisticated regarding his colleagues' feelings about him, and his manipulative behavior tends to be extremely well developed.

Physician addicts tend to come to the attention of their colleagues several months or years after the onset of addiction.[1] Often the underlying psychiatric difficulties and mood swings, rather than the addiction itself, are evident first, and physician addicts frequently first come to the attention of legal authorities through routine audits by the Drug Enforcement Administration or police audits of pharmacy records. The State Medical Board is then contacted and the circumstances are investigated. Few physicians are arrested directly for narcotics misuse in Ohio.

It is interesting that although physicians are among the most intelligent people in our society, they often are exceedingly careless when it comes to hiding their addictions from the authorities and/or their colleagues; it becomes quite obvious that they are crying for help.

Pharmacology of Narcotic Drugs

No discussion of management of narcotic dependency can be complete without some review of the actions of the narcotics as a drug class and of the differences between these drugs. This is even more important when dealing with the physician whose dependency on a myriad of drugs is commonplace.

The narcotic drugs all are derivatives of opium or semisynthetic or synthetic, opium-like drugs. They all have similar effects: they relieve pain and anxiety by a little-understood mechanism; they have a depressant effect on respiration; but more important for this discussion, in sufficient doses over sufficient periods of time, they all produce physical dependence, are tolerance producing, and cause cross dependence.[2] It is important to add that although the different narcotics vary in potency, they are *equally effective* in decreasing narcotic withdrawal symptomatology.

The main differences in the narcotic drugs are their duration of action at equally effective doses and their absorption through the gastrointestinal tract. Therefore, they all are interchangeable in the treatment of narcotic dependency, and as will be seen later, the main choices will relate to their duration of action and gastrointestinal absorption. Parenthetically, since none of the narcotics (except oral methadone) has a duration of action approaching 24 hours, users of almost all narcotic drugs commonly have continued difficulties in maintaining a degree of comfort. Hence, they usually must consume multiple doses throughout the day and night, thereby decreasing their productive ability further.

It also must be mentioned that although the narcotic drugs are considered quite dangerous by law enforcement officials and society in general, these drugs are known to be quite safe even over the long term. Physical effects of narcotic drugs are almost always related — not to the drug itself, but to the administration or to the effect of general debilitation. Such complications as thrombophlebitis (usually arms, often complicated by cellulitis) and hepatitis are commonplace, but they are not a direct drug effect.

Treatment Issues

The physician addict must be hospitalized if there is to be any chance for success even in initial detoxification. It may be possible under some circumstances, using an established detoxification program, to detoxify a physician on an outpatient basis, but short-term, outpatient detoxification usually has poor results. Often the physician addict is on extremely high doses of "pure" narcotics and possibly on multiple drugs. In addition, the physician has essentially unlimited access to drugs, indicating the necessity of some control which probably can only be optimally achieved on an inpatient basis.

Although the treating physician must be very skeptical of the patient's history, he should include an accurate history of drug intake, including kinds and amounts, in his evaluation of the physician addict. Therapeutic and laboratory (urine drug screen) confirmation is essential. Although narcotic withdrawal usually is not a serious problem in healthy people,[3] unrecognized, coexistent, barbiturate and/or alcohol withdrawal may have serious sequelae. Physical conditions such as heart disease also should be taken into account since severe stress caused by too rapid narcotic detoxification could precipitate a physi-

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cal problem that any undue stress might cause.

After determining from the history the types and amounts of drugs the physician addict uses every day, the treating physician must evaluate the reality of the circumstances. The physician addict often will overestimate the amount of drugs being taken. (This is true of the "street" addict as well.) Therefore, it is incumbent on the treating physician to give a smaller dose than requested.

Naloxone should be kept available when treating narcotic addicts, especially when first starting a regimen. Special care must be taken to assure its availability. Oftentimes, it is on an emergency room tray but not in the inpatient area of the hospital where it may be needed.

Having secured as much drug history as was possible to obtain from the patient, calculating an initial regimen then becomes the crucial judgment. The author halves the daily dose taken by the patient and divides that daily dose into every-three-hour increments. Initially, the same drug as the patient has been taking is continued unless it is heroin (a rare drug for physicians to take). In such a case, one can switch to morphine or methadone, but this must be done extremely carefully since the dosage of the heroin must be treated as an unknown.

Given a smaller-than-requested dose, the patient is started on a lower dose of the drug and is not given more than necessary. By observing the patient over the first 24 hours for *signs* of physiologic withdrawal (diaphoresis, diarrhea, nasal stuffiness), rather than relying on subjective symptoms (abdominal cramps, weakness), the attending physician can increase or decrease the dosage.

In the beginning, the patient is told that if he or she is uncomfortable to ask for an injection, noting that they may only be given the drug at a maximum of every three hours. The patient is not told the dosage of the drug. As an initial ground rule before admission, the patient is asked to agree that dosage of the drug is solely the responsibility of the treating physician. Floor nurses are asked: (1) not to indicate dose amount to patient; (2) to watch for spurious visitors bringing drugs in; and (3) to keep the total amount of liquid in the syringe, if possible, at no less than 2 cc in order to prevent the physician from determining dosage. Oftentimes, in dealing with the narcotic-dependent physician, discussion of these precautions is attempted in advance of admission.

Jaffee and Martin[2] suggest a somewhat different approach, prescribing methadone immediately, rather than initially using the drug being taken by the patient. This is quite acceptable although, in many cases, the physician addict, as previously mentioned, presents problems somewhat different from those of the usual "street addict."

Example 1. Patient states he or she is taking 2,000 mg meperidine intravenously daily. Following the scheme described herein, divide 1,000 mg (one-half the stated dose) into every-three-hour doses, or 125 mg given intramuscularly every three hours. Since the calculated divided dose is in the normal therapeutic range, starting at 150 mg every three hours would not be unreasonable — adjusted after several hours, if necessary.

Example 2. Patient states his or her daily intake is 1,600 mg morphine sulphate intravenously. (Although this seems to be an extremely high dose of morphine, it is not unknown for a physician addict to take such a quantity of a narcotic.) In this case, the treating physician would, using the formula, administer 100 mg morphine intramuscularly as a first dose. Since this is some five to ten times the usual therapeutic dose, the treating physician may want to give a test dose of some 20 to 30 mg first and observe the patient for signs of overdose or withdrawal.

Physiologic withdrawal of the narcotic can be accomplished in a number of ways. An estimation must first be made as to the seriousness of the addiction, so an estimation as to long- or short-term detoxification is most appropriate.

Long-Term Detoxification

This is accomplished with the long-acting drug, methadone. Since this involves several months' time, the important in-hospital goals are to transfer the patient from morphine to methadone therapy, decrease the 24-hour, total-narcotic dose as much as possible (hopefully, below the morphine equivalent of 60 mg per day), and arrange for outpatient maintenance and detoxification in an approved program. There may be some resistance on the part of the physician addict to participate in a program with street addicts, so again, if long-term maintenance or detoxification is to be used, this requirement should be made an early ground rule.

Long-term detoxification is accomplished by using liquid methadone in a blind procedure in which the patient is not aware of his daily methadone dose. With the advent of long-acting methadone (1-alpha acetylmethadone), some patients on long-term detoxification will only have to report to an approved program every three days. With short-acting methadone, once-a-day attendance is required. Methadone can be substituted for any of the narcotic drugs.

Morphine subcutaneously and methadone orally can be interchanged on a milligram-for-milligram basis although some authors prefer giving less methadone.[3] However, it is the author's experience that even a milligram-for-milligram interchange can cause some physiologic signs of withdrawal, and an initial increase may be necessary. For example, if an individual is taking 20 mg morphine sulphate subcutaneously every four hours (total morphine in 24 hours then being 120 mg), 120 mg methadone given orally once a day, or every 12 hours, should prevent withdrawal symptoms. All other narcotics can be substituted in like manner. (Meperidine, 100 mg, and hydromorphine hydrochloride, 2 mg, equals approximately 10 mg of morphine. The necessary methadone dose can be calculated easily.)

Short-Term Detoxification

Short-term detoxification often can be achieved using the standard prescribed narcotics. If the patient is taking

one of those (meperidine or morphine), that narcotic can simply be withdrawn slowly over the course of several days in the hospital, or methadone can be substituted and decreased 20 percent each day. Short-term detoxification often is not effective over a long period, but circumstances may make it the most efficacious route occasionally. It is very difficult to accomplish if the patient is using very high doses; it cannot be done successfully on an outpatient basis under any circumstances.

Methadone

Special mention must be made of the narcotic drug, methadone. In action or effect, it is no different than morphine, heroin, meperdine, or any other narcotic drug except for two important facts: (1) it is long acting, its antiwithdrawal effects lasting 12 to 36 hours; and (2) it tends to be well absorbed from the gastrointestinal tract.

Although it is as "addicting" as any narcotic drug, these two exceptions make it extremely useful in problems of narcotic addiction. Its long duration of action allows for a stabilization of narcotic blood levels, which usually cannot be achieved with the individual being given shorter-acting narcotics. This stabilization decreases the "highs" (euphoria) and "lows" (withdrawal symptoms) with which users of injectable, short-acting, narcotic drugs must deal on a continuous basis. It must be mentioned, however, that decreasing the euphoria may be very uncomfortable psychologically for narcotic addicts and intensify their difficult behavior. Obviously, its advantage of good gastrointestinal absorption makes it easy to administer, and since it usually is given in liquid form in established programs, the dose can be adjusted carefully without the patient knowing the amount of the drug. Unfortunately, because of its misuse in some instances, this drug is only available to treatment personnel.

Extra Medical Considerations

Three important points need to be stressed in dealing with narcotic-addicted physicians:

1. Manipulative Behavior.— The treating physician must be aware at all times that the physician addict often will be as manipulative as any street addict. He or she will do anything possible to obtain narcotics, including feigning illness or pain (in both of which the physician addict is greatly experienced and sophisticated). In addition, the physician addict may attempt to bring drugs to the treatment area from the outside. It, therefore, becomes incumbent upon the treating physician to be extremely skeptical of any unusual problems that arise during the course of detoxification from narcotic drugs.

2. Rigid Limits Needed.— Because of the manipulative behavior and the apparent internal needs of many addicted patients, it is essential that rigid limits be set from the very beginning. This should include a clear understanding between the treating physician and the drug-dependent physician regarding the treatment goals and the expectations of each. (A written document can be used for this.)

3. Reentry.— This may become the most difficult process, in that legal circumstances may prohibit the physician-addict from practicing medicine. Yet, it is essential that the physician, upon reentering society, begin the redevelopment of his or her value system and have a position of employment that will limit postwithdrawal depression, malaise, irritability, and boredom, all of which may last for several months.[4] On occasion, physician addicts have been placed in part-time volunteer positions eventually leading to full-time paid positions. Unlicensed physicians can perform record reviews and administrative duties; institutions often will accept them on a volunteer basis. However, the institution must be willing to deal with the supervision problems or success is not likely to be achieved. It is essential that strict limits be placed on the physician addict during this process so that he or she is well aware of the consequences of any misdeeds.

Summary

The physician addict presents some unique characteristics for the treating physician. Such difficulties as use of high doses of pure narcotic drugs, the taking of multiple drugs, sophisticated manipulative behavior, and job reentry difficulties of a unique nature, present the treating physician with a complex task requiring a great deal of patience and understanding as well as the ability to set severe limits for dealing with very difficult behavior in a colleague.

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The Role of the Ohio State Medical Board in the Case of an Impaired Physician

William J. Lee, Administrator of the Board,
With Linda A. Jacobson*

THE OHIO STATE MEDICAL BOARD is the licensing and disciplinary organization governing medical practice in the State of Ohio. As such, it can become involved in the case of an impaired physician. Often, this occurs when the physician has not or will not voluntarily undertake treatment for his disabling condition. In such instances, the primary purpose of the Medical Board is to protect the public and to assist the physician within the parameters of the law.

According to a survey conducted by the American Medical Association, impaired physicians are affected most often by alcoholism and drug dependence. However, mental illness and senility may also be causes of tragic situations which often result in suicide.

About four years ago, some Ohio physicians began to think about ways to aid the disabled physician. They recognized that there was no confidential source for such physicians to appeal to for help. In addition, it was recognized that most physicians with a problem would not face up to the situation and seek assistance on their own.

The Ohio State Medical Association Physician Effectiveness Program was developed from these thoughts. (See "The Ohio State Medical Association Physician Effectiveness Program" by Robert D. Clinger in this issue.) The Ohio plan has "teeth" in that there is a final consequence if disabled physicians are unwilling to recognize their need for help. This consequence is a report to the Ohio State Medical Board. Conversely, the Medical Board may often refer a physician to the OSMA Physician Effectiveness Program.

It is extremely important that a physician effectiveness program incorporate a disciplinary plan, and discipline must be responsive to the facts in each case. A competent and strong investigative program to enforce the law should accompany such a plan. Such enforcement, of course, protects the public; but it may also be a form of treatment for the disabled physician, forcing him to "heal" his problem. For both reasons, discipline cannot be too soft.

Once the Ohio State Medical Board is involved in the case of a disabled physician, it follows the terms of the Medical Practice Act and affords the physician in question full due process of the law:

Administrative Due Process

The State Medical Board, along with other agencies, is governed by the Administrative Procedure Act (Chapter 119, Revised Code). When an alleged violation of the Medical Practice Act (Chapter 4731, Revised Code) occurs, the physician or limited practitioner cannot have his license summarily taken away. He must be afforded the rights of due process provided by the Constitution and by the Administrative Procedure Act. Action cannot be taken on hearsay or innuendo. Any complainant, including Medical Societies, should furnish the Board with name of witnesses and first hand information if it is available. The licensee must be given formal notice of the alleged violation and he has thirty days in which to request a formal hearing. When a hearing is requested, a time must be set and the licensee given a full opportunity to present his side or position concerning the alleged violation. It should be noted that the licensee may request a continuance of the hearing date for good cause and a reasonable extension of time must then be given to avoid due process procedural problems. He is entitled to be represented by counsel and he may present evidence and examine witnesses for and against him. A formal record is made at the adjudication hearing. Many times the hearing extends over many days because of the complexities of the evidence and law involved. After the hearing, the State Medical Board then has to reach a decision. Once the decision is reached, the licensee must then be formally notified of the decision. If the decision is adverse to the licensee, he has a right to appeal to the Court of Common Pleas and has certain appellate rights which go to the Court of Appeals, the Supreme Court of Ohio and the Supreme Court of the United States. During the appeal, the licensee has a right to continue to practice if he can show undue hardship to the Court and frequently this right is granted. The Courts may only sustain the decision of the Board if the decision is in accordance with law and is supported by reliable, probative and substantial evidence, not by rumor nor second hand complaint but testimony of first hand witnesses whether patients, practitioners or others.

The Medical Board receives an initial report from one of many sources: family; peer; patient; public; local or state medical society; or local, state, or federal law enforcement body. This report is confidential; however, should the case ultimately reach a formal due-process hearing, the identity of the individual will probably come to light.

After the report is received, the Medical Board conducts a confidential investigation to ascertain the validity of the complaint. Such individuals as acquaintances of the physician in question, pharmacists, patients, and law enforcement officials will be contacted. Hearsay and innuendo are not acceptable forms of evidence. If the

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Mr. Lee, Columbus, Administrator, State Medical Board of Ohio since 1970; previously, Assistant Attorney General, Office of the Attorney General, State of Ohio.

*The material for this article came from an interview with Mr. Lee conducted April 27, 1977.

Medical Board must ultimately make an issue of the case, the Administrative Procedure Act requires reliable, substantial, and probative evidence.

There has been much discussion of expeditious action on the part of the Board in cases of disabled physicians. Once the Board has determined that a problem warranting license surrender does exist, it makes a concerted effort to get the physician to surrender his or her medical license. In 1976, the Board achieved 16 voluntary surrenders of license. However, such cooperation is not always achieved. In 1973, we recommended to the Governor's Task Force on Health that the Medical Board be empowered to take a medical license prior to the formal hearing when an emergency endangering the public health exists, with a subsequent, expeditious, formal due-process hearing.

The OSMA Physician Effectiveness Program is extremely important because the issue of the impaired physician's condition is immediately confronted by the district liaison physician. In this manner, the case can be brought to an early conclusion involving treatment for the impaired physician and possibly surrender of his medical and narcotic licenses. (It should be noted that removal of the physician's narcotic license should relieve him of threats and annoyances from persons seeking drugs for other than medical reasons.) The exciting aspect of the OSMA Physician Effectiveness Program is that it can resolve a problem much more rapidly than lengthy due process procedures.

The Ohio State Medical Board conducts two types of hearings: The investigational (informal) hearing and the citation (formal) hearing. The investigational hearing occurs after the preliminary investigation of the physician in question has occurred. This physician is asked to appear before the secretary or another member of the Board. (During 1976, 68 practitioners were invited to appear.) The physician in question is given the Miranda warning and then is confronted with the problem. A positive result from this hearing can be resolution of the problem and treatment of the physician and, therefore, protection of his patients. A substantial number of cases have been resolved in this way.

Generally, the citation hearing is used with the more serious problems; and the informal hearing is often dispensed with in these cases. Unfortunately, the length of time involved in due process action often allows an impaired physician to continue in practice. Again, this situation makes the OSMA Physician Effectiveness Program very important.

Should an impaired physician relinquish his medical license, seek treatment for his condition, and recover, he can reapply for practice privileges in Ohio. When he reapplies, he will be asked to appear before the Medical Board. At that time, he will supply evidence that he is competent to practice medicine. (Usually, this evidence is the testimony of two psychiatrists.) Also, he will demonstrate that he has complied with all treatment conditions. If the Board reissues his license, they may do so under certain restrictions: continued treatment by a psychiatrist, reappearance before the Board, or withholding the use of the narcotic license.

It is extremely encouraging to us when an impaired physician recognizes his problem, seeks treatment, and recovers. There is often a great acceptance of a recovered physician by his patients, who will generally stand by him. Of course, there exist the hard-core cases, which are rough and tough problems. Unfortunately, some physicians' problems are so extreme that they do not become resolved, often resulting in suicide. These are the cases we lose, and they can really upset us.

The most positive note is that help does exist for the disabled physician in Ohio. Help that should lead to eventual cure! The Ohio State Medical Association Physician Effectiveness Program is an excellent support to conventional law enforcement. If this program cannot reach a disabled physician, the Ohio State Medical Board must do everything within its power to continue to protect the public and to see that justice is rendered, including treatment, with rehabilitation when appropriate.



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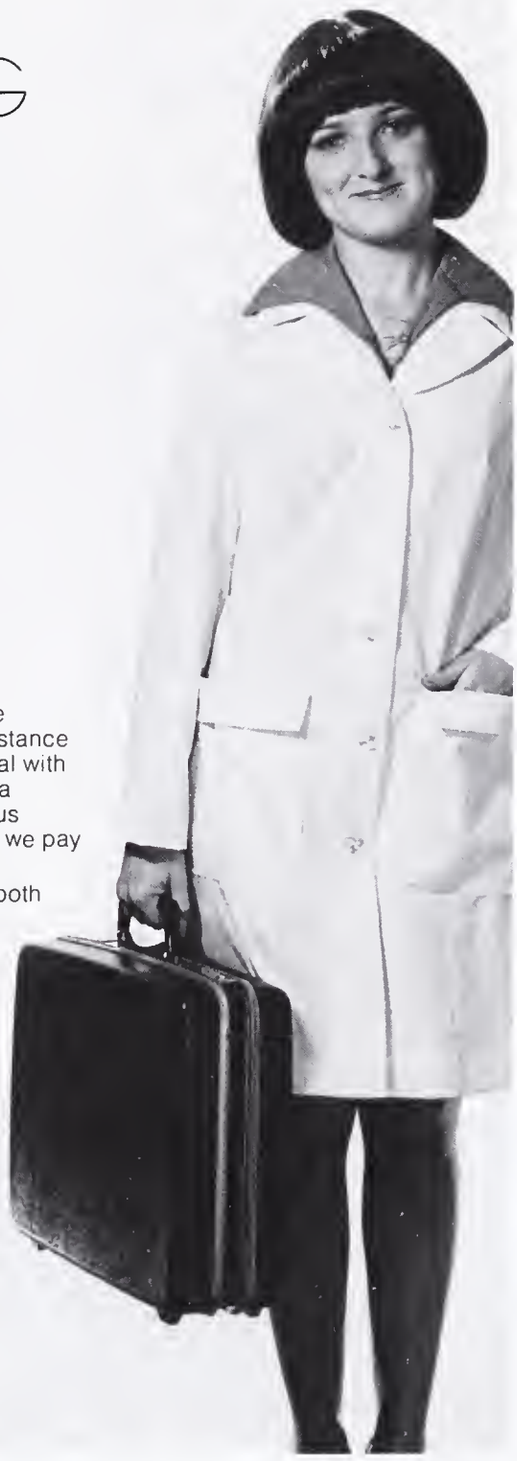
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THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 10, 1977 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

ATTENDANCE

OSMA Council Present: William M. Wells, M.D., Newark, President; John J. Gaughan, M.D., Cleveland, President-Elect; George N. Bates, M.D., Toledo, Past President; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stewart B. Dunsker, M.D., Cincinnati, First District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; Theodore J. Castele, M.D., Cleveland, Fifth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor. Absent: W. J. Lewis, M.D., Dayton, Second District Councilor; and J. Hutchison Williams, M.D., Columbus, Tenth District Councilor.

Guests Present: P. John Robechek, M.D., Cleveland, Chairman, Ohio Delegation to the AMA; John H. Ackerman, M.D., Columbus, Director, Ohio Department of Health; and James E. Pohlman, Esq., Columbus, OSMA Legal Counsel. Representing MAI: William R. Schultz, M.D., Wooster; Oscar W. Clarke, M.D., Gallipolis; Edward A. Lentz, Columbus; Alfred F. Hartmann, Columbus; and Lucille E. Cotner, R.N., Columbus.

OSMA Staff Present: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Linda A. Jacobson, Rick Ayish, David C. Torrens, and Judy Franklin.

ADMINISTRATION DEPARTMENT

The minutes of the July 9, 1977 meeting of the Council were **approved.**

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics were reported by Mrs. Wisse, showing OSMA current membership 47 ahead of December 31, 1976, and a gain of 373 members over August of last year.

Committee on Auditing and Appropriations

The minutes of the September 9 meeting of the Committee on Auditing and Appropriations were presented by Dr. Rinderknecht, and were **approved.** Items considered and approved were:

(1) Expenditures of $2,138.70 from the Malpractice Research Fund;

(2) Appropriation of $1,400 to conduct a program to increase AMA membership in Ohio;

(3) A position paper with regard to the establishment of criteria for direct dues billing by the AMA, where such is indicated by failure of counties and states to obtain AMA members;

(4) Authorize the officers to negotiate a purchase price in terms for acquisition of a strip of property adjacent to the present OSMA building site;

(5) Officials of *The Ohio State Medical Journal* were authorized to enter into a four-color process printing contract; and

(6) The allowance of the AMA delegates and alternates was adjusted temporarily to meet with the problem of heavy expenses for the San Francisco meeting of the AMA.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Commission on Medical Education

Minutes of the Commission on Medical Education meeting on July 21, 1977 were reported by Mrs. Dodson and were **approved.**

Committee on Scientific Work

Minutes of the Committee on Scientific Work meeting on August 20, 1977 were presented by Mrs. Dodson and were **approved,** with the exception of an item with regard to expenses for physician monitors for cosponsored category I CME programs. It was requested that this item be submitted to the Committee on Auditing and Appropriations.

GOVERNMENT MEDICAL CARE DEPARTMENT

Medical Advances Institute

The Council convened in closed session to hear a presentation by William R. Schultz, M.D., Chairman of the Board of Directors of Medical Advances Institute (MAI). The Council adjourned the closed session and reconvened in regular session.

A motion **was approved** authorizing the OSMA to guarantee a $75,000 loan sought from The Huntington

National Bank by Medical Advances Institute. The loan proceeds are to be used by MAI solely in connection with the performance of a nursing home review contract and legal counsel was instructed to review and approve the terms of the loan, regarding repayment and appropriate security.

Ohio Medical Indemnity, Inc.

Mr. Gillen reported for the Liaison Committee of Ohio Medical Indemnity, Inc. (OMI).

The Council authorized the Association to provide to OMI names of physicians who might serve on a committee to assist with the OMI "medical necessity project" involving certain medical procedures.

DEPARTMENT OF ORGANIZATION SERVICES

Task Force on Professional Liability

The minutes of the Task Force on Professional Liability meeting on July 27, 1977 were reported by Mr. Campbell and were approved.

Recommendations approved by the Council included participation in the Jeppesen-Sanderson patient education program and the purchase of selected hardware materials in connection with the program.

American Medical Association

Dr. P. John Robechek reported for the Ohio Delegation to the AMA and called attention to the fact that in December, the AMA House of Delegates would, for the first time, meet separately from the AMA Scientific Program.

Joint Underwriting Association

Mr. Campbell presented statistics from the Joint Underwriting Association (JUA) and announced that Richard L. Fulton, M.D., has been appointed to the Loss Committee of the JUA.

PICO

Mr. Page presented the following report of the Physicians Insurance Company of Ohio:

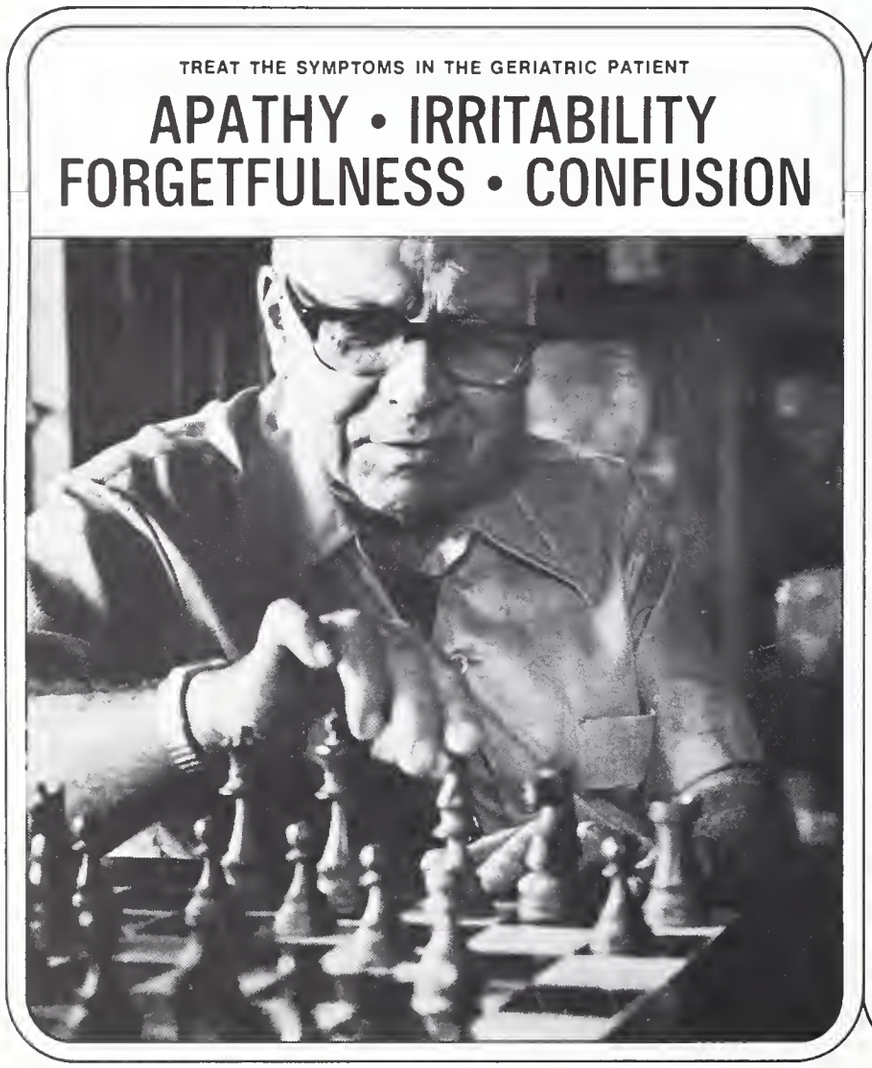
As of September 2, 1977:

Primary applications received in 1977	2,612
Excess applications received in 1977	342
Primary policies in force	2,127
Excess policies in force	253*
*does not reflect additional excess policies issued by agents not yet reported to Home Office.	
Premiums written in 1977	$10,698,126
Stock sold in 1977	3,481,000**
**does not reflect stock sold in 1976 ($3,100,000)	

DEPARTMENT OF HEALTH EDUCATION

Sports Medicine

Mr. Clinger discussed the 1977 Sports Medicine Awards which were presented during the All-Star Ohio



High School Football Game at Canton, Ohio. He announced that criteria for next year's awards would be available soon.

Physician Effectiveness Program

It was announced by Mr. Clinger that a number of county medical societies now have active Physician Effectiveness Committees.

Mr. Clinger and Arnold M. Leff, M.D., were authorized to assist in the planning of the AMA Regional Conference on Drug Abuse on September 16, 1977, in Chicago.

Health Manpower

The Council discussed the article "The Physician's Assistant," appearing on pages 637 through 638 of the September issue of *The Ohio State Medical Journal*. The President was authorized to discuss guidelines with Sanford Press, M.D., of the Ohio State Medical Board.

DEPARTMENT OF FEDERAL LEGISLATION AND PUBLIC POLICY

The Council received a copy of the transcript of the AMA-Washington conference call held on August 10, 1977.

DEPARTMENT OF STATE LEGISLATION

Messrs. Mulgrew and Ayish discussed a number of State legislative proposals affecting medicine and public health and advised that Council would be kept informed of developments during the fall Ohio General Assembly sessions.

S.B. 314 (Butts, D-Cleveland) was reviewed.

COMMUNICATIONS DEPARTMENT

Ms. Doll presented the report of the OSMA Department of Communications and the Seminar for County Medical Society Public Relations Committees, presently scheduled for November 5, 1977.

FIELD SERVICE DEPARTMENT

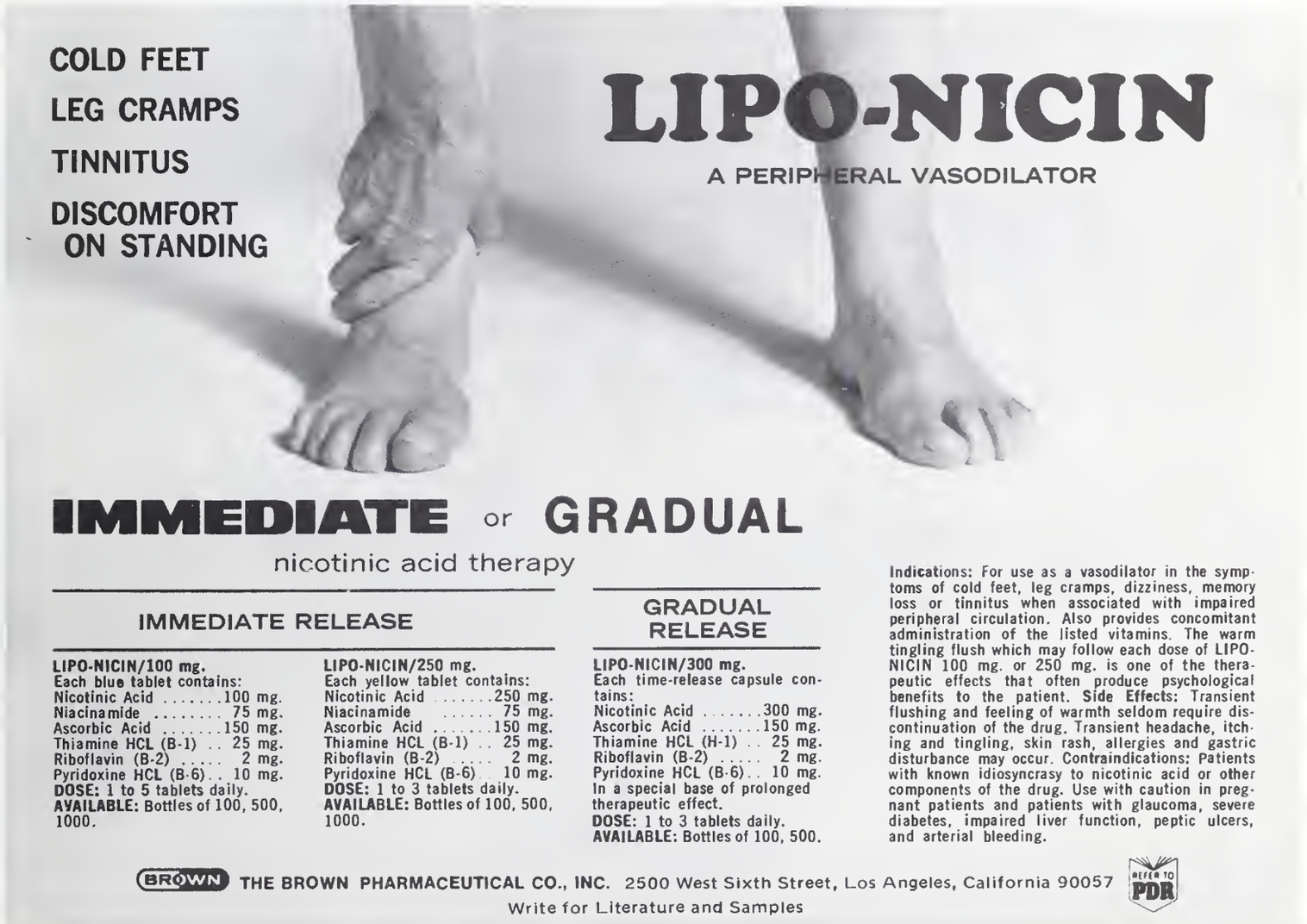
Mr. Holcomb reported on the Annual Meetings of the American Association of Professional Standard Review Organizations and the American Association of Foundations for Medical Care.

COUNCILOR REPORTS

The Councilors reported on activities in their districts.

LEGAL COUNSEL REPORT

Mr. Pohlman presented information on Medical Services Review Committees, International Rehabilitation



Associates, the Physician Effectiveness Program, and the status of Resolution 77-77.

Messrs. Pohlman, Clinger, and Mulgrew were authorized to work out possible amendments to Section 2305.25 of the Revised Code in order to facilitate exchange of information when properly indicated in the Physician Effectiveness Program.

DIRECTOR OF HEALTH

Dr. John H. Ackerman reported on the identification of several cases of "Legionnaires Disease" in the Columbus area. Dr. Wells congratulated Dr. Ackerman and Dr. Thomas J. Halpin on the handling of the public information aspects of this problem.

Dr. Ackerman distributed copies of the 1977 issue of the booklet *Laboratory Services Available in the Ohio Department of Health.*

It was announced by Dr. Ackerman that he would try to obtain funds from the Ohio Board of Control to assist in a program at Columbus Children's Hospital involving treatment of epilepsy in children.

Mr. Clinger commended Dr. Ackerman for his cooperative work with the Ohio Department of Education in the advancement of immunization programs in the schools of Ohio.

DR. MORGAN NOMINATED

The Council received a letter from the Gallia County Medical Society nominating Thomas W. Morgan, M.D. for the office of President-Elect of the OSMA.

OHA RISK MANAGEMENT PROGRAM

The Council voted to endorse the Malpractice and Accident Prevention Program developed by the Ohio Hospital Association.

AD HOC COMMITTEE ON DRUG GUIDELINES

The Council discussed the necessity to develop guidelines for physicians in the treatment of patients who have been on drugs for long periods of time. The President was authorized to appoint an ad hoc committee to meet with the officials of the Ohio State Bar Association on this matter.

MISCELLANEOUS COMMUNICATIONS

The Council received a letter from the Louisiana State Medical Society, dated August 8, 1977, regarding a newly formed group called "Doctors of Concern."

In answer to a request from the publishers of *Physicians Desk Reference,* the Executive Director was authorized to release the OSMA mailing list, contingent on satisfactory legal arrangements.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page
Executive Director

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The Auxiliary Project Bank

Ingrid May, OSMA Auxiliary President

Doctor, are you interested in promoting an upgraded immunization program; a VD-awareness campaign; or a hot, home-delivered meals program for the elderly? If so, turn to your local medical auxiliary for assistance!

Doctor Albert Schweitzer once said: "It is not enough merely to exist, you must give some time to your fellow man, even if it is a little thing. Do something for those who need man's help— for which you get no other pay but the privilege of doing."

The OSMA Auxiliary does have the privilege of educating and informing our fellow citizens on health-related topics. The proof that we care about our neighbors is our *Project Bank.*

What is the Project Bank?

In 1975, the Project Bank began as a unique method for sharing auxiliary projects from county to county or state to state. It is a service provided by our national auxiliary so that state and county auxiliaries can obtain materials on community service projects developed and implemented by other auxiliaries across the country. Ohio is one of the top contributors to the Project Bank, which contains more than 500 programs.

How Does the Project Bank Work?

Programs developed and implemented by county and state auxiliaries are sent to the Project Bank through the state coordinator and the national area counselor. Mrs. Armin Melior, Lucasville, is Ohio's coordinator for 1977-1978; and Mrs. William Myers, Circleville, is the area counselor for the states of Ohio, Michigan, Indiana, Illinois, and Wisconsin.

At national headquarters, each submitted program is written in a standardized format, catalogued, and filed. This file is the Project Bank Catalog. All projects are organized into the following divisions: aging, blood donor, childen and youth, family life, fund raising, health careers, health education, international health, mental health, and safety screening. Auxiliaries use project bank information request forms to gain access to a specific health-oriented project. In addition, Ohio has ten catalogs on hand to circulate throughout our county auxiliaries.

Does the Project Bank Make a Difference?

Ohio county auxiliaries have used the Project Bank for help in perfecting programs in a variety of areas. Ohioans who benefitted from these many activities include:

* The elderly in Scioto County are happier because they became participants in the auxiliary's Senior Citizen Program.
* To the parents faced with the compounded problems of child abuse, the programs developed by the auxiliary to the Cuyahoga County Academy of Medicine made all the difference in the world.
* The Hamilton County Auxiliary developed an outstanding child care center, "The Apple Tree," for pre-school children of mothers in the medical field.

Other projects have supplied the funds for paramedical and nursing scholarships, a mobile meals program, and both loan and endowment funds. Health education has been promoted and medical supplies have been sent abroad as a result of other activities. And all of these projects have been shared with other states through the Project Bank.

The Project Bank has stimulated the imagination and creative potential of Ohio auxilians. We are hopeful that our projects, perfected on the county level, will be equally as stimulating to auxilians in other states. We are proud of our success stories!

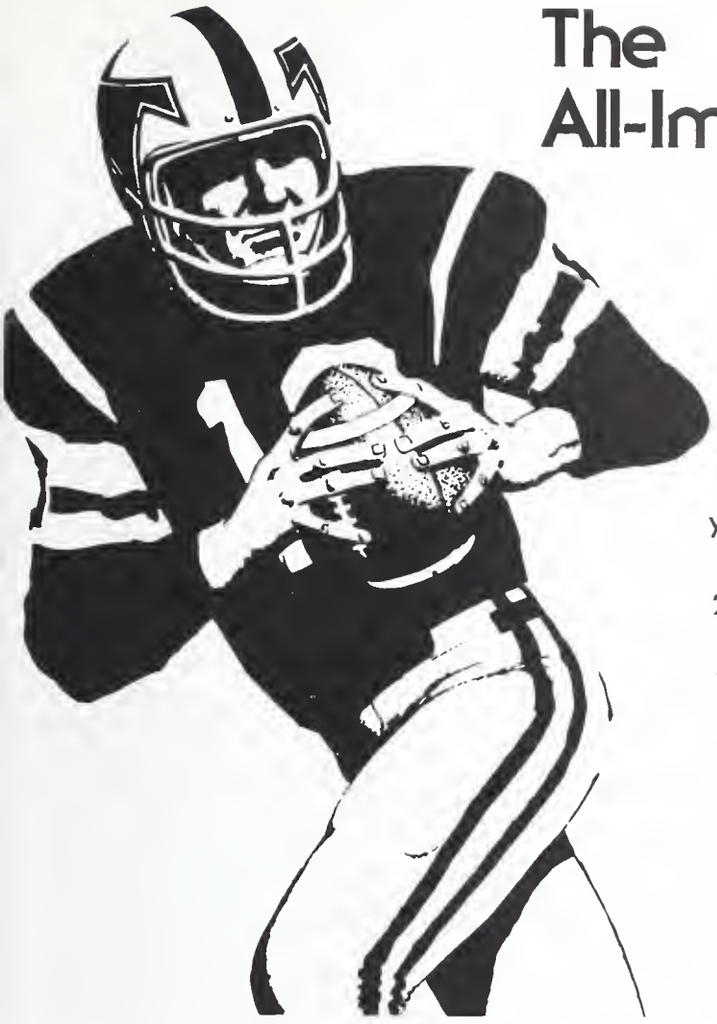
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THE OHIO STATE Medical Association Medical School Highlights

Medical College of Ohio Welcomes New President

Richard D. Ruppert, M.D., former Vice-Chancellor for Health Affairs of the Ohio Board of Regents, is the new President of the Medical College of Ohio at Toledo. Dr. Ruppert became President of the Medical College of Ohio on October 1, 1977, following Marion C. Anderson, M.D., as the third president of the College. Dr. Anderson resigned to accept an appointment as Chief of Surgical Services at the Charleston (South Carolina) Veterans Administration Hospital and Professor and Vice Chairman of Surgery at the Medical University of South Carolina in Charleston.



Richard D. Ruppert, M.D.

A specialist in diseases of the stomach and intestine, Dr. Ruppert became Vice-Chancellor for Health Affairs of the Ohio Board of Regents in 1974 from an administrative position at The Ohio State University College of Medicine. At the Ohio Board of Regents, Dr. Ruppert directed a study to determine dental needs in Ohio and helped to prepare the master plan for higher education in Ohio in 1976.

Having received his medical degree from The Ohio State University College of Medicine in 1961, Dr. Ruppert returned to the University Hospitals for a residency in internal medicine following completion of an internship at Presbyterian-St. Luke's Hospital, Chicago. After his residency and a gastroenterology fellowship at The Ohio State University Hospitals, the Ohio native became a member of the OSU faculty in 1966 as an instructor in the Department of Medicine's Division of Gastroenterology. He was promoted to assistant professor of medicine in 1968, to associate professor in 1970, and to professor in 1974. In 1970, he was named assistant dean and director of the Department of Medicine's Division of Ambulatory Medicine. He became medical director for patient services at The Ohio State University Hospitals in 1972.

Dr. Ruppert says he is proudest of his formation of an ambulatory outpatient department at OSU. His program was the second one in the nation financed by the federal government. This financing included an $8.5 million grant for construction of an outpatient facility. Dr. Ruppert also numbers among his accomplishments the financing and approval by the State of Ohio of a family medicine program at The Ohio State University. This program was later expanded to other state schools. In addition, he mentions developing six regional health manpower planning agencies which opened the way for area health education councils.

Named Man of the Year by The Ohio State University College of Medicine in 1976, he received the Physician Recognition Award from the Ohio Academy of Family Physicians the same year.

Dr. Ruppert is certified by the American Board of Internal Medicine. He is also a member of a variety of other organizations including the American Society of Internal Medicine, the Society for Teachers of Family Medicine, the American Federation for Clinical Research, the American Association of Medical Colleges, and the American Medical Association. On the state level, Dr. Ruppert belongs to the Ohio State Medical Association, the Academy of Medicine of Columbus and Franklin County, the Ohio Society and the Columbus Society of Internal Medicine, and the Medical Forum of Columbus.

Dr. Ruppert's wife Elizabeth is a practicing pediatrician and professor in The Ohio State University College of Medicine. They are the parents of four daughters, aged 14 to seven years.

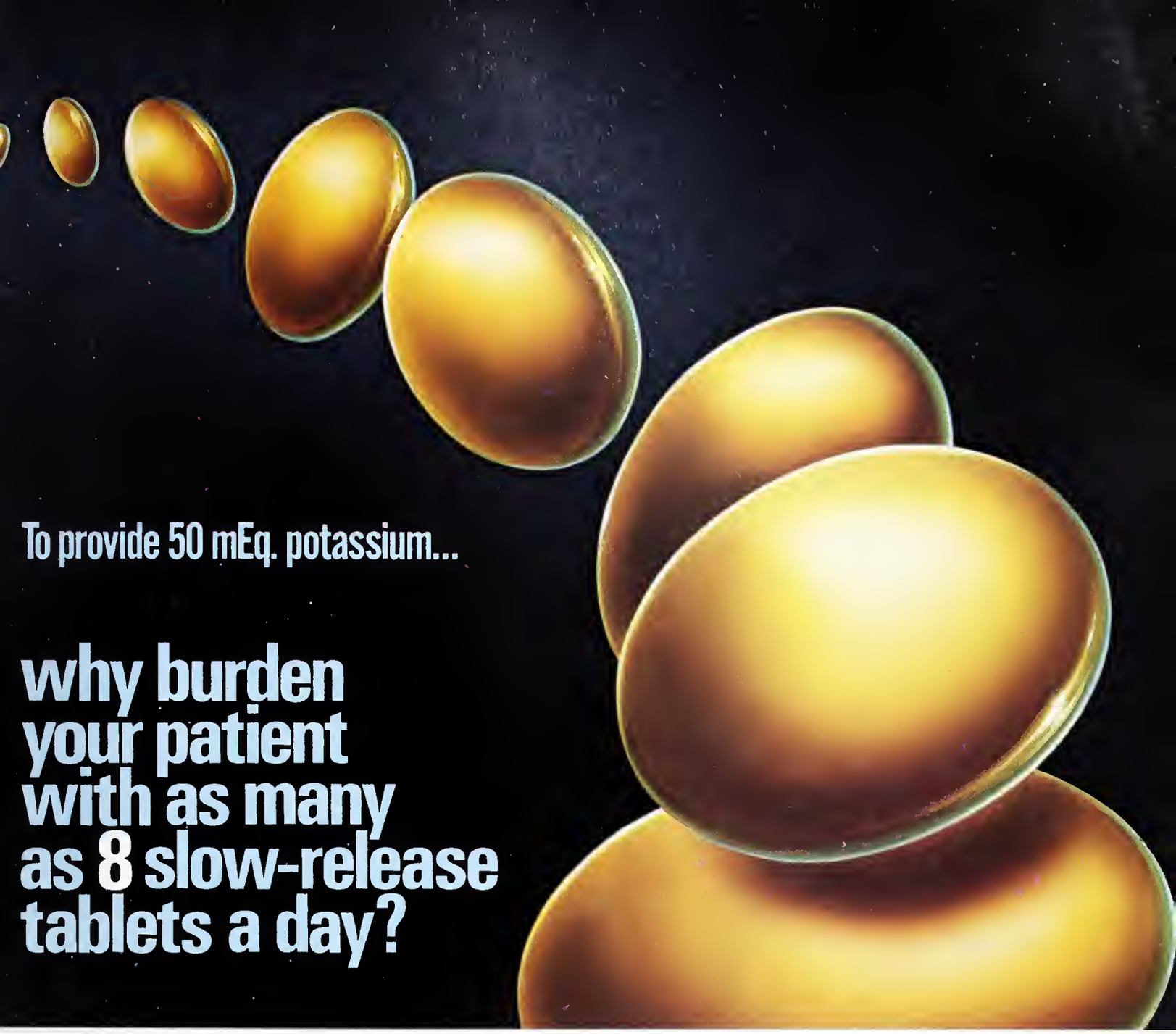
Dr. Frank F. A. Rawling, Vice-Chairman of the Medical College of Ohio Board of Trustees, said of Dr. Ruppert: "An experienced medical educator with seven years' service in academic administration, Dr. Richard D. Ruppert is well prepared to assume the leadership of the Medical College of Ohio. He has demonstrated the rare ability to speak effectively to the diverse constituencies which a modern health sciences center must serve including the medical community, the people's elected representatives, and the public at large as well as the faculty and student body."

Dr. Ruppert said of his move to the Medical College of Ohio: "It is exciting to move to a setting that is in the process of growth and development. And, Toledoans have a great interest in the medical school, it's obvious."

Among his goals is growth in ambulatory programs. He wants to establish a balance between inpatient and outpatient care so that students will feel as comfortable in the office setting as in the hospital. He also looks forward to consolidating all faculty on the new west campus from buildings on the east campus. This consolidation will be an economic move.

Of his predecessor, Dr. Ruppert said: "(Dr. Marion Anderson) has done a superb job for a new school and that makes my job easier. There is a lot of great faculty, and that all makes it easier— especially when the people are eager and aggressive."

(School Highlights continued on page 774)



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Warnings and Precautions: Since the amount of potassium deficiency may be difficult to determine accurately, supplements should be administered with caution, and dosages adjusted to the requirements of the individual patient. Potassium intoxication rarely occurs in patients with normal kidney function. Symptoms of potassium intoxication are variable. They include listlessness, mental confusion, and tingling of the extremities. Frequent checks of the clinical status of the patient, ECG, and serum potassium level are desirable. In established hypokalemia, attention should also be directed toward other potential electrolyte disturbances. Potassium supplements should be given cautiously to digitalized patients and such patients should be monitored by ECG for cardiac irregularities. To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, **patients should be carefully directed to dissolve each dose completely in the stated amount of water.**
Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort may occur with the use of potassium salts.
Dosage and Administration: Adults: 1 tablet (25 mEq. potassium) completely dissolved in **3 to 4 ounces of cold or ice water,** 2 to 4 times daily, depending upon the requirements of the patient. The normal adult daily requirement is approximately 50 mEq. of elemental potassium. NOTE: **It is suggested that this product be taken with meals and sipped slowly over a 5-10 minute period.**
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Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted

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The Ohio State Medical Association Medical School Highlights

Case-Western Reserve

FREDERICK C. ROBBINS, M.D., Dean of Case Western Reserve School of Medicine, will begin a sabbatical year in Washington, D.C. in November. Dean Robbins' principal responsibility will be as consultant to the Institute of Medicine (IOM) of the National Academy of Sciences (NAS); and he will also be associated with the Office of Technology Assessment (OTA), one of three advisory agencies of Congress.

Active in the National Academy of Sciences for the past ten years, Dean Robbins has participated in IOM studies on polio vaccine, the health impact of legalized abortion, and the health-care needs of children. He is a member of the Board of Maternal, Child, and Family Health of NAS and has worked on several of the regular NAS forums.

Dr. Robbins has been associated with OTA advisory council since its inception. He serves as chairman of its Health Advisory Panel and has participated in several studies on health matters on which later legislation has been based. The most recent study, which he chaired, concerned the medical implication of the use of saccharin.

EDGAR LEE, M.D., Dean for Administration and Hospital Programs, will assume the post of Acting Dean of the School of Medicine in Dr. Robbins' absence. Dr. Lee joined the Case Western administration and faculty in 1970 as Associate Dean for Administration and assumed the additional responsibility for hospital programs in 1974. He is also Case Western Reserve School of Medicine Assistant Professor of Community Health and Pathology.

Northeastern Ohio Universities

Northeastern Ohio Universities College of Medicine has announced promotions in academic rank for five physicians serving as chairmen of clinical councils. Promoted from associate professor to professor were:

WILLIAM H. BUNN, JR., M.D., The Youngstown Hospital Association, Clinical Council Chief for Internal Medicine;

WILLIAM A. COOK, M.D., Akron General Medical Center, Clinical Council Chief for Obstetrics/Gynecology;

DOUGLAS M. EVANS, M.D., Akron General Medical Center, Clinical Council Chief of Surgery;

JOHN D. KRAMER, M.D., The Children's Hospital Medical Center of Akron, Clinical Council Chief for Pediatrics; and

JOHN P. SCHLEMMER, M.D., West Side Family Practice Center, Clinical Council Chief for Family Practice.

EUNICE R. CARTER, M.D., Past Chairman of the Department of Family Practice at Akron City Hospital, has been appointed Coordinator for Undergraduate Curriculum in Family Practice and Associate Professor of Medical Education for Northeastern Ohio Universities College of Medicine. Dr. Carter, who conducted a private practice in family medicine in Cuyahoga Falls from 1946 to 1976, will be responsible for assisting in the development of goals, objectives, and implementation of a family practice curriculum for the College of Medicine. Currently, Dr. Carter holds the rank of Clinical Assistant Professor in the Department of Preventive Medicine at The Ohio State University College of Medicine and is a member of the senior active staff in family practice at Akron City Hospital.

JAMES E. FLEMING, M.D., Cleveland, is a new member of the Board of Trustees of Northeastern Ohio Universities College of Medicine, having been appointed by consortium university Kent State. An internist in private practice, Dr. Fleming serves as area medical consultant to the Bureau of Vocational Rehabilitation, Cleveland; medical director for Community Action Against Addiction; and consultant to the Health, Education, and Welfare Bureau of Hearings and Appeals. He has also been Senior Instructor of Clinical Medicine at Case Western Reserve University School of Medicine since 1970.

HAROLD J. JEGHERS, M.D., Medical Director of St. Vincent Hospital, Worcester, Massachusetts, has been named Professor of Medical Education in the Office of Medical Education Research and Curriculum Development of Northeastern Ohio Universities College of Medicine. Dr. Jeghers, who received his medical degree from Western Reserve University Medical School, developed the Medical Index Project. This is a large file of clinically relevant articles which have been selected from medical journals over the past 40 years to provide a clinical case and problem-oriented reference to articles selected from about 300 major journals worldwide.

Ohio State University

JAMES CERILLI, M.D., Columbus, has been elected to a two-year term as Secretary of the American Society of Transplant Surgeons. Professor of Surgery at The Ohio State University College of Medicine, Dr. Cerilli has been Director of the Transplant Program at

University Hospital since 1967. He is also a member of the Medical Advisory Board of the Kidney Foundation of Central Ohio, the Editorial Board of the journal *Transplant*, and the American Surgical Association.

C. JOSEPH DeLOR, M.D., has been named Professor Emeritus of The Ohio State University College of Medicine. A member of the Department of Medicine, Dr. DeLor has been a faculty member of the University for 47 years. He is also a graduate of the College of Medicine.

ARTHUR G. JAMES, M.D., Clinical Professor of Surgery at The Ohio State University College of Medicine and Medical Director of the Columbus Cancer Clinic, has assumed the Lucius A. Wing Chair of Cancer Research and Therapy at the University. Dr. James is a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgery, and a former president of the American Cancer Society, on whose board of directors he now serves.

KARL P. KLASSEN, M.D., Professor and Director of the Division of Thoracic Surgery at The Ohio State University College of Medicine, has been appointed to the Karl P. Klassen Chair of Surgery, which was established in his honor at the University. A Fellow of the American College of Surgeons and the American College of Chest Physicians, Dr. Klassen serves on the boards of trustees of the Central Ohio Heart Association and the Center for Science and Industry.

ROBERT J. MURPHY, M.D., Columbus, received a citation from the American College of Sports Medicine at its 1977 annual meeting. An internist, Dr. Murphy has been head team physician at The Ohio State University since 1971, having served as associate team physician since 1952. Dr. Murphy is also a member of the Joint Advisory Committee on Sports Medicine of the OSMA and the Ohio High School Athletic Association. He is the 1977 recipient of the Committee's Special Award for Outstanding Contributions to Sports Medicine in Ohio. The citation presented by the College of Sports Medicine read in part: ". . . Dr. Murphy is a dedicated practicing internist, a great humanitarian, an outstanding team physician and a great benefactor in sharing his knowledge of problems in sports medicine."

The Ohio State University has announced three appointments at University Hospitals. **DOUGLAS A. RUND, M.D.,** Assistant Professor in the Department of Family Medicine, has been appointed Director of the Division of Emergency Medical Services. **MICHAEL WHITCOMB, M.D.,** has been named Director of the Division of Pulmonary Diseases. Before joining the University Hospitals, Dr. Whitcomb served as Chief of the Pulmonary Disease Service at Boston University Medical Center. **RONALD WHISLER, M.D.,** has been appointed Director of the Division of Rheumatology of the Department of Medicine. Dr. Whisler joined the faculty recently after a fellowship at the Mayo Clinic.

JAMES V. WARREN, M.D., Columbus, has been designated a Master of the American College of Physicians. Chairman of the Department of Medicine of The Ohio State University College of Medicine, Dr. Warren was one of nine physicians in the United States and Canada to receive this honor. An American College of Physicians spokesman said of Dr. Warren: "(His) scientific contributions in the field of circulatory physiology and disease are outstanding. With his colleagues, he was a principal in defining the effects of disease on cardiac output and he has made important contributions to the understanding and prevention of sudden cardiac death."

RONALD WHISLER, M.D., has recently been appointed Director of the Division of Rheumatology, Department of Medicine, The Ohio State University College of Medicine. Dr. Whisler joined the faculty from the Mayo Clinic.

MICHAEL WHITCOMB, M.D., has been named Director of the Division of Pulmonary Disease of The Ohio State University College of Medicine. Before joining the Hospitals, Dr. Whitcomb served as Chief of the Pulmonary Disease Service at Boston University Medical Center. **WILLIAM R. DOMBY, M.D.,** also from Boston University Medical Center, was named Assistant Professor of Pulmonary Diseases.

ROBERT E. ZOLLINGER, M.D., Columbus, recipient of the 1977 Dr. Rodman E. Sheen and Thomas G. Sheen Award of the AMA, was recently awarded the Founders' Medal by the American Surgical Association. This medal is presented for distinguished service to surgery. Dr. Zollinger served as the Chairman of the Department of Surgery of The Ohio State University College of Medicine for 28 years.

University of Cincinnati

The Housestaff Association of the University of Cincinnati Medical Center has announced the election of **MICHAEL FEDERLE, M.D.,** third-year resident in radiology, as president. Vice-presidents are **GILDEN BLACKBURN, M.D.,** a fourth-year resident in obstetrics/gynecology; **PETER KOTCHER, M.D.,** a second-year resident in psychiatry; and **C. THOMAS MEYER, M.D.,** fourth-year resident in orthopaedic surgery. **ANDY ROTH, M.D.,** third-year resident in orthopaedic surgery, is treasurer; and **WILLIAM RUPP, M.D.,** second-year resident in medicine, is secretary.

DONALD G. LANGSLEY, M.D., Director of the Department of Psychiatry at the University of Cincinnati College of Medicine, is the first recipient of the Harold Miles Award. This award is presented by Genesee Hospital, which is affiliated with the University of Rochester (New York) School of Medicine and Dentistry. Dr.

(continued on page 777)

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School Highlights *(continued)*

Langsley taught at the University of Colorado, then headed the psychiatry department at the University of California School of Medicine, Davis, before joining the University of Cincinnati Medical Center in 1976.

RICHARD C. LEVY, M.D., has been named Acting Director of the Emergency Department at the General Hospital of the University of Cincinnati Medical Center. The department is one of the largest in the midwest, caring for 200,000 patients each year. In addition, the emergency medicine residency program at General Hospital, established in 1970, was the first in the United States. Dr. Levy is a member of the American College of Emergency Physicians, the University Associates of Emergency Medical Services, and both the OSMA and the AMA. Among his many Cincinnati activities is serving as a physician volunteer for the helicopter team, Doctorcoptor.

Wright State University

The Dayton Veterans Administration Center has been awarded a $370,000 grant from the Veterans Administration, Washington, D.C., to study ways of improving the quality of domiciliary patient care. This is the largest grant ever received by the Center and reflects its increased emphasis on research and education. Under the guidance of **JOSEPH D. ALTER, M.D.,** and **C. ALEX ALEXANDER, M.D.,** multidisciplinary health professional teams will be used to provide primary health care to 840 domiciliary patients at the Center. Dr. Alter is Chief of Domiciliary Medical Service at the Center and Clinical Professor and Acting Chairman of the Department of Community Medicine of Wright State University School of Medicine. Dr. Alexander is the VA center's Chief of Staff and is Clinical Professor, Department of Community Medicine, in the Wright State University School of Medicine.

JOON J. LEE, M.D., has been appointed Assistant Professor in the Department of Anesthesiology of the Wright State University School of Medicine. Dr. Lee, who comes to the School of Medicine from the University of Minnesota Hospital, will be based at Miami Valley Hospital, where she will work in the Perinatal Center and will pursue her interest in respiratory therapy.

JAMES F. SCHIEVE, M.D., Kettering, was recently appointed Vice President of Medical Affairs at Good Samaritan Hospital and Health Center. Formerly Associate Dean for Hospital Affairs at Wright State University School of Medicine, Dr. Schieve will continue his affiliation with the school as a voluntary clinical professor in the Department of Medicine.

Residents

EDWARD T. BOPE, M.D., a resident at the Riverside Family Practice Center in Toledo, has been selected as one of 18 recipients of the 1977 Mead Johnson Award for Graduate Education in Family Practice. Dr. Bope received a "Certificate of Award" and $1,200 for one year of training in family practice beginning July 1, 1977. He was evaluated on the basis of scholastic achievement, leadership qualities, and qualification for, and interest in, family practice.

CHARLES CHRISTOPHER, M.D., Dayton, has been named a recipient of the Mead Johnson Award for Graduate Training in Obstetrics and Gynecology for 1977. This award is intended to aid deserving young physicians planning careers in the specialty of obstetrics and gynecology. Dr. Christopher is one of eight recipients of the award for 1977.

C. NICHOLAS WALZ, M.D., Toledo, is among the first group of winners of the Warner/Chilcott Teacher Development Award. Nine recipients were selected from a total of 95 third-year, family practice residents who applied. Each of the winners received $1,400 to aid in entering family practice and teaching family practice on a part-time basis. Dr. Walz was a family practice resident in the Mercy Hospital Family Practice Residency Program, Toledo. He will teach in the same program.



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THE OHIO STATE Medical Association Obituaries

EVERETT ARCHDEACON, M.D., Dayton; Loyola University Stritch School of Medicine, Maywood, Illinois, 1951; age 54; died September 4; member OSMA and AMA.

OLLIE M. GOODLOE, M.D., Columbus; University of Louisville School of Medicine, Louisville, Kentucky, 1932; age 73; died September 9; member OSMA and AMA.

FOREST C. HANEY, M.D., Columbus; Ohio State University College of Medicine, 1917; age 87; died September 9; member OSMA and AMA.

GEORGE B. HAYDON, M.D., Cincinnati; University of Cincinnati College of Medicine, 1938; age 64; died September 19; member OSMA and AMA.

ROBERT A. HENDRICKS, M.D., Maumee; College of Medicine University of the Philippines, Manila, 1957; age 57; died September; member OSMA and AMA.

HERMAN H. IPP, M.D., Miami Beach, Florida; Ohio State University College of Medicine, 1935; age 67; died August 26.

LASZLO F. KOLCSEY, M.D., Renton, Washington; Orvosi Fakultas Szegedi Orvostudomanyi, Egyetem Szeged, Hungary, 1927; age 74; died March 19, 1975; member OSMA and AMA.

JAMES G. QUINLAN, M.D., Toledo; University of Western Ontario Faculty of Medicine, London, Ontario, 1926; age 77; died September; member OSMA and AMA.

RUDOLPH S. REICH, M.D., Cleveland; Case Western Reserve University School of Medicine, 1915; age 88; died September 7; member OSMA and AMA.

ALBERT R. SMITH, M.D., Columbus; Duke University School of Medicine, Durham, North Carolina, 1934; age 70; died September 12; member OSMA and AMA.

CHARLES I. THOMAS, M.D., Cleveland; Case Western Reserve University School of Medicine, 1935; age 69; died August 27; member OSMA and AMA.

ALEXANDER A. WEECH, M.D., Gainesville, Florida; Johns Hopkins University School of Medicine, Baltimore, Maryland, 1921; age 81; died August 18; member OSMA and AMA.

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The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

November 1977

THE TRAUMA PATIENT: CARE AND COMPLICATIONS: November 14-16; Marriott Motor Hotel, 4277 W. 150th St., Cleveland; sponsor: American College of Surgeons; cosponsor: Department of Surgery, Case Western Reserve University School of Medicine; 19 credit hours; fee: $200, $75 interns, residents, nurses; contact: Mark A. Mandel, M.D., 2065 Adelbert Road, Cleveland 44106, phone: 216/791-7400.

CLINICAL GASTROENTEROLOGY: November 16-17; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CHOLECYSTITIS AND CHOLEDOCHOLITHIASIS: November 17; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, General Surgery, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

CLINICAL EXPERIENCES WITH CARCINOEMBRYONIC ANTIGEN IN CARCINOMA OF THE COLON: November 19; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

December 1977

PORTAL HYPERTENSION: December 1; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, Director of Education, General Surgery, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

PERSPECTIVES IN OPHTHALMOLOGY: December 1-2; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150; $75 students and physicians-in-training; contact: Penn G. Skillern, M.D., Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

DIAGNOSTIC ULTRASOUND: December 3, 8:30 AM; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

GENETICS IN YOUR MEDICAL PRACTICE: December 7; Ramada Inn, 330 West First Street, Dayton; sponsor: Department of Pediatrics, Wright State University School of Medicine; 6 credit hours; fee: $25; contact: Arlene Polster, Program Coordinator, WSU School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

SHALL I CALL A SURGEON— TODAY'S CONCEPTS, METHODS, AND RESULTS: December 7, 9 AM-5 PM; Lutheran Medical Center, Cleveland; 6 credit hours; fee: $50; contact: CME Office, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland 44113, phone: 216/696-4300.

PERIANAL PATHOLOGY: December 15, 8:30 AM; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

PHYSIOLOGY OF ENDOCRINE SURGERY— PART I: December 15, 8 AM; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, General Surgery, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

MUSCULOSKELETAL REHABILITATION: December 23, 12 NOON; Kettering Medical Center, Kettering; 1 credit hour, contact: Elvin C. Hedrick, M.D., Kettering Medical Center, 3535 Southern Boulevard, Kettering 45429, phone: 513/298-4331, ext. 278.

January 1978

PHYSIOLOGY OF ENDOCRINE SURGERY— PART II: January 5; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

WHERE THE HEALTH DEPARTMENT FITS IN THE COMMUNITY: January 5; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

IMPOTENCE: January 7; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

COMMON SURGICAL PROBLEMS AND THEIR MANAGEMENT: January 11 and 12; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150, $75 students and residents; contact: Penn G. Skillern, M.D., Center for Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

THE OHIO STATE MEDICAL BOARD: ITS PHILOSOPHY AND FUNCTION: January 12; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, 614/383-6301, ext. 292.

THE OHIO STATE Medical Association News

Some Medical Firms Need License As Terminal Distributor Of Dangerous Drugs

In 1962, the Dangerous Drug Distribution Act was enacted in Ohio. This Act provides that individuals who are licensed as medical practitioners in the State are exempt from licensure as terminal distributors when they purchase drugs in their own name and the drugs are used exclusively by the individual practitioner on his own patients.

However, when drugs are in a name other than that of an individual practitioner (ie, clinic, hospital, corporation, association) or if two or more practitioners are using the drugs from a common stock and the drugs are the property of the firm, the firm must be licensed as a Terminal Distributor of Dangerous Drugs.

Applications for a license as a Terminal Distributor of Dangerous Drugs can be obtained from the Ohio State Pharmacy Board, 180 East Broad Street, Suite 1126, Columbus, Ohio 43215. The cost of the license is $30.

Birth, Death, and Stillbirth Certificates Revised

The standard certificates of birth, death, and stillbirth used in the United States have been revised. The new revisions, as adapted by the State of Ohio, will be placed in use January 1, 1978.

The formats of the new certificates have been revised to provide for national uniformity. The following items have either been added to the new certificates or have been modified:

Birth Certificate

Birth Weight (Item 20): To be reported in grams.

Apgar Score (Item 21): To be reported at one- and five-minute intervals.

Prenatal Visits (Item 22b): Total number to be reported.

Clinical Estimate of Gestation (Item 25): Gestation in weeks by clinical estimate is to be reported.

Pregnancy History (Item 17): Item pertaining to the history of previous pregnancies has been modified to collect more meaningful and accurate data.

Origin or Descent of the Mother and Father (Items 14 and 15): Should be reported with information obtained from the informant that, in the opinion of the informant, best describes the national origin or descent of the mother and father.

Death Certificate

Place of Death (Item 7d): If a death occurs in a hospital or institution, Item 7d should indicate whether the status of the deceased was DOA, outpatient, emergency room, or inpatient. Item "inside city limits" as it pertains to the place of death has been deleted from the certificate.

Medical Certification: Format has been revised. Several items in the medical section have been changed including the certification signed by the attending physician.

Origin or Descent of Deceased (Item 9): Should be completed with information obtained from the informant that, in the opinion of the informant, best describes the national origin or descent of the deceased.

Stillbirth Certificate

The additions and modifications are very similar to the changes in the birth certificate.

Questions regarding the revisions in the certificates of birth, death, and stillbirth may be referred to the Division of Vital Statistics, Ohio Department of Health, Ohio Departments Building, Room G-20, 65 South Front Street, Columbus, Ohio 43215.

Medical Board Activity

The following is a list of activities and actions undertaken from August 1, 1977 to August 31, 1977 by the Ohio State Medical Board.

LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	112
	D.O.	30
Licensed by Examination	M.D.	97
	D.O.	2
Foreign Medical School Graduates		
Licensed by Endorsement		63
Licensed by Examination		71
Sept. 1972 FLEX Board Policy Licenses		0
Endorsements to Other States	M.D.	28
	D.O.	0

ENFORCEMENT ACTIVITY

Formal Citations Issued	2
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	5
Voluntary Surrenders of Medical Certificates	0
Arrests for Alleged Illegal Practice of Medicine	2
Formal Hearings on Alleged Violations of the Medical Practice Act	2

Lorain County Medical Foundation Presents Student Scholarships

At a recent meeting of the Lorain County Medical Society, the Board of Supervisors of the Lorain County Medical Foundation presented scholarships to students studying various medical professions. Among the recipients were Joseph Fog of Amherst, a third-year student at Case Western Reserve University School of Medicine; and Holly Gae Henderson, also of Amherst, a first-year student at Wright State University School of Medicine.

The 14 recipients were selected from 89 students who made application for the scholarships. The finalists were chosen on the recommendation of a screening committee chaired by John B. McCoy, M.D. The scholarships distributed this year, which vary in amount depending on the field of study, bring the total amount awarded by the Medical Foundation to $39,775.

The scholarship program was established in 1963 with surplus funds from the 1962-1963 Sabin Oral Polio Vaccine Program cosponsored throughout Lorain County by the Medical Society and area health departments. Over the years, the Medical Society's Auxiliary has been a prime benefactor of the scholarship program, having donated approximately $21,940 since 1968.



LEFT TO RIGHT: Medical student Joseph Fog, who received a Lorain County Medical Foundation scholarship; John B. McCoy, M.D.,; and Mr. Otto B. Schoepfle. (Photograph courtesy *The Chronicle-Telegram,* Elyria.)

U.S. POSTAL SERVICE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. TITLE OF PUBLICATION: Ohio State Medical Journal	A. PUBLICATION NO.	2. DATE OF FILING: Sept. 28, 1977
3. FREQUENCY OF ISSUE: Monthly	A. NO. OF ISSUES PUBLISHED ANNUALLY: 12	B. ANNUAL SUBSCRIPTION PRICE: $10 domestic

4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, City, County, State and ZIP Code) (Not printers)*: 900 E. State Street, Athens, Ohio 45701 (Athens County)

5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*: 600 S. High Street, Columbus, Ohio 43215 (Franklin County)

6. NAMES AND COMPLETE ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and Address)*: Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215

EDITOR *(Name and Address)*: Linda A. Jacobson, 600 S. High Street, Columbus, Ohio 43215

MANAGING EDITOR *(Name and Address)*: Hart F. Page, 600 South High Street, Columbus, Ohio 43215

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stock holders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

NAME	ADDRESS
Ohio State Medical Association A non-profit corporation with no stock outstanding.	600 S. High Street, Columbus, Ohio 43215

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES *(If there are none, so state)*

NAME	ADDRESS
None	

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES *(Section 132.122, PSM)*

The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

[X] HAVE NOT CHANGED DURING PRECEDING 12 MONTHS [ ] HAVE CHANGED DURING PRECEDING 12 MONTHS *(If changed, publisher must submit explanation of change with this statement.)*

10. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES PRINTED *(Net Press Run)*	11,633	11,850
B. PAID CIRCULATION 1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	-0-	-0-
2. MAIL SUBSCRIPTIONS	10,884	11,186
C. TOTAL PAID CIRCULATION *(Sum of 10B1 and 10B2)*	10,884	11,186
D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	523	514
E. TOTAL DISTRIBUTION *(Sum of C and D)*	11,407	11,700
F. COPIES NOT DISTRIBUTED 1. OFFICE USE, LEFT OVER, UNACCOUNTED, SPOILED AFTER PRINTING	226	150
2. RETURNS FROM NEWS AGENTS	-0-	-0-
G. TOTAL *(Sum of E, F1 and 2—should equal net press run shown in A)*	11,633	11,850

11. I certify that the statements made by me above are correct and complete.

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER: Linda A. Jacobson

12. FOR COMPLETION BY PUBLISHERS MAILING AT THE REGULAR RATES *(Section 132, Postal Service Manual)*

39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rates presently authorized by 39 U.S.C. 3626.

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER

PS Form 3526 Mar. 1977 *(Page 1)* (See instructions on reverse)

physicians, consider a practice in **south carolina.**

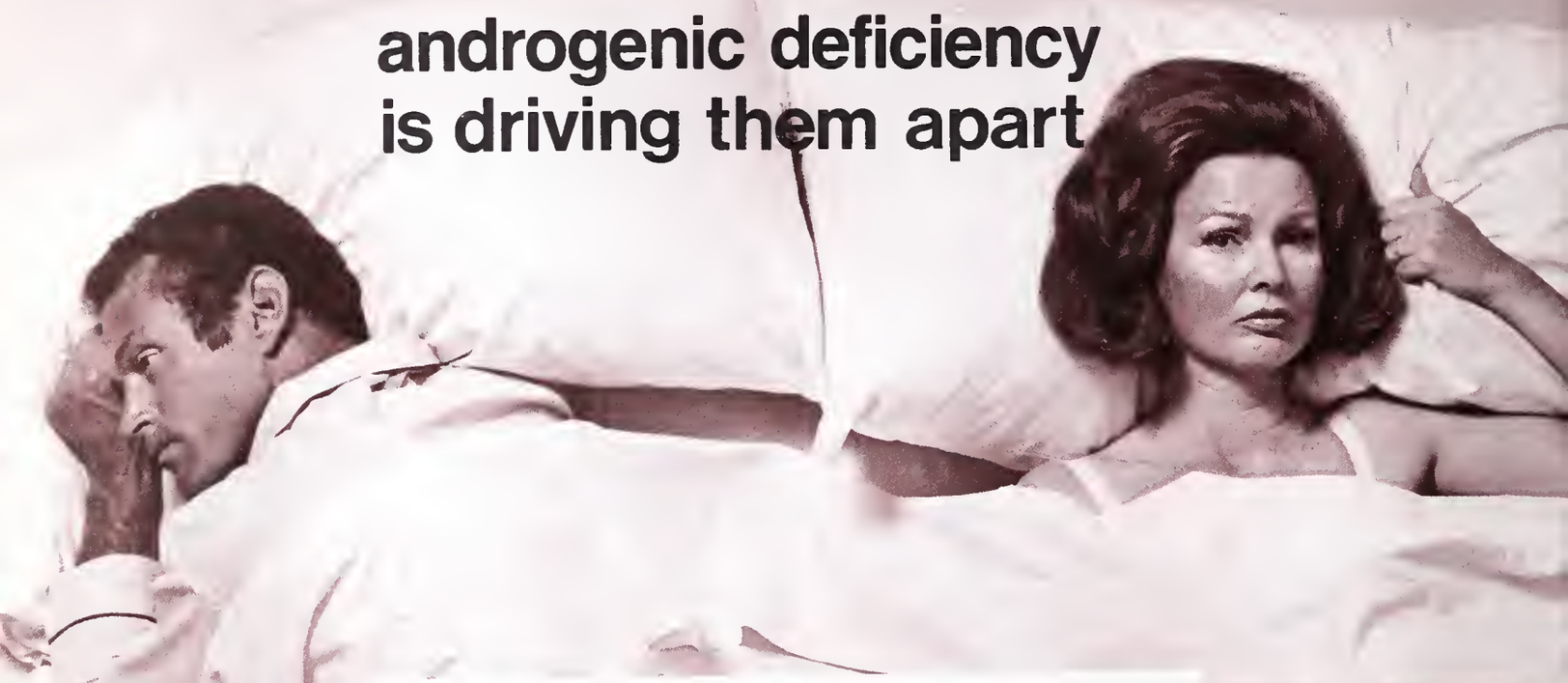
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New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Rates: $2 per line. Display classified: $4 per line. (1978 Rates: $3 and $5 respectively.) Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

FAMILY PHYSICIANS WANTED: One or two, resident graduates or board eligible or certified to join two-man group. Large office, semi-rural small town, local college, good schools, excellent 325-bed local community hospital 35 miles from Columbus, Ohio. Great place to practice, live and raise a family. Granville Medical Center, Inc., Granville, Ohio, 43023, phone: 614/587-0115.

MARION, INDIANA: One internist, board eligible or certified. Permanent license any state required. Salary open to $38,000 depending on qualifications and experience. Special bonus pay of about $6,000 available. 40-hour work week, 30 days vacation, 15 days paid sick leave, 9 paid holidays, low-cost life and health insurance, excellent retirement plan. Moving expenses paid. Contact Frank J. Salvati, M.D., Chief of Staff, VA Hospital, Marion, Indiana 46952. Phone 317/674-3321, collect.

EQUAL OPPORTUNITY EMPLOYER

PSYCHIATRIST: For community mental health center using case-manager model. Begin $41,600. Board eligible. 32 hours per week. Private practice allowable. Liberal fringes. Moving expenses. Open October 1, 1977. Resume/three reference letters to Personnel, Scioto Paint Valley Mental Health Center, 50 Pohlman Road, Chillicothe, Ohio 45601, telephone 614/775-1260.

EQUAL OPPORTUNITY EMPLOYER

FAMILY PHYSICIAN: Take over the practice I must leave Jan. 1, 1978. Service poor folk who need and appreciate you. Includes mobile clinic. ER provides coverage. Net $50,000 plus. Surround yourself with woods, wild flowers, and waterfalls in SW Ohio. Contact Terry Chappel, M.D., Box 548, West Union, Ohio 45693, phone 513/587-3527.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

PHYSICIAN'S OFFICE FOR RENT: German Village, Columbus. Waiting room, reception room, consulting room, and two examination rooms. Completely furnished. A/C. $250 per month plus utilities. Phone 614/443-9407.

MARION, OHIO: Excellent opportunities to practice medicine. Existing and new, solo, partnership, and association. 250-bed, excellently equipped, regional-medical-center hospital within walking distance from offices. Industry and agriculture support city/county of 65,000 and total trade area of 250,000 people. Excellent schools, 50-minute easy drive to Columbus, reliable cross coverage.

OB/GYN
FAMILY PRACTICE
INTERNAL MEDICINE
PEDIATRICS
GENERAL SURGERY
PHYSICAL MEDICINE

Send CV or contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302. Phone 614/382-8211 or 382-3442.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Avenue, Willoughby, Ohio 44094, phone: 216/946-4546.

E.N.T.: Unexpected retirement has created immediate need for board-qualified ENT physician. Excellent community, excellent hospital. Facilities and equipment available. Contact Robert Flint, Physician Relations, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

EMERGENCY DEPARTMENT PHYSICIAN-CLEVELAND, OHIO: New emergency group desires career-minded emergency physicians. Opportunity is unlimited. Superior starting salary; vocational and educational leave; malpractice and hospital insurances paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal, M.D., President, Medical Emergency Services, Inc., phone: 216/398-4141 ext. 388, or 216/831-4095.

INTERNIST / FAMILY PRACTICE PHYSICIAN: Preferably with a background or interest in atherosclerotic cardiovascular disease, behavior modification, compliance to therapy, or epidemiology. Sought for position in Lipid Research Division, Department of Internal Medicine. Suitable candidate will be offered a faculty position with teaching and clinical research opportunities at the University of Cincinnati Medical Center. Interested candidates should forward curriculum vitae to Box 812 c/o Ohio State Medical Journal.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third physician. New facility. Excellent hospital within walking distance. Contact Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

INTERNIST-CARDIOLOGIST to associate with another internist-cardiologist in busy practice in northeast Ohio. Many fringe benefits. Send resume to Box 808 c/o Ohio State Medical Journal.

FOR SALE—EXCELLENT OPPORTUNITY: Columbus, corner lot, next door to Mount Carmel Medical Center West. Large enough for doctor's or dentist's office, medical laboratory, or drug outlet. Call evenings after 7 PM: 614/870-6189 or 274-9791.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

(Classified Ads continued on page 788)

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

STAFF PSYCHIATRIST: Position available at 85-bed, state psychiatric hospital. Receiving and acute care services, also occasional extended care cases. Hospital has two-year accreditation as a psychiatric hospital by the JCAH. New 30-bed wing under construction. Potential for challenging program development.

Ohio license and board-eligible or board-certified in psychiatry and neurology required. Salary range $40,000-$45,000. Liberal fringe benefits and retirement plan. Scenic area of Ohio. Outstanding recreational facilities in vicinity. Hospital located on southern border of Ohio. Population 26,000. Call or write Henry Hogan, M.D., Medical Director, Portsmouth Receiving Hospital, 25th and Elmwood Road, Portsmouth 45662, phone: 614/354-2804.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

PEDIATRICIANS WANTED: Excellent opportunity for one or two board certified or eligible pediatricians. We have guarantees, office space, computerized billing, and office organizational business assistance available for the right physicians. City of 18,000 with growing service area of 38,000. Close to Cleveland, and very good recreational areas- sailing, skiing, tennis, all locally. New office available within one to two minutes walk of hospital. Contact Patrick J. Martin, at Fisher-Titus Memorial Hospital, 272 Benedict Avenue, Norwalk, Ohio 44857.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

LIMA STATE HOSPITAL, a 400-patient Forensic Center, has positions available for physicians and psychiatrists to work in administrative, clinical, or staff capacities. Salaries range from $30,000 to $50,000 commensurate with qualifications, education, and assigned functions. An Ohio license or eligibility for a license is a requirement. For more information, please submit vitae to: Personnel Office, Lima State Hospital, Drawer Q, Lima, Ohio 45802. Telephone: 419/222-5075.

FAMILY PRACTITIONERS NEEDED: Growing community of over 4,000 needs one or two M.D.'s. Two F.P.'s in town and one nearby. Join existing practice or solo available. Excellent recreational and economy. Sixty miles from metro-cities, 57-bed J.C.A.H. hospital in community. Trade area of over 12,000. Contact L. Wattier, Administrator, Memorial Hospital Inc., 104 W. 17th, Schuyler, Nebraska 68661, phone: 402/352-2441.

ASSOCIATE WANTED: Cincinnati Professional Corporation seeks associate. Openings available in emergency rooms and medical centers doing family practice and industrial cases. Medical Health Services, Inc., 5002 Ridge Ave., Cincinnati, Ohio 45209. Telephone: 513/631-0200.

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See ***The Journal***, Vol. 73, No. 10, page 723, October 1977 for additional listings.)



PEDIATRICIAN: Currently available. Desires location in community that is rural with metropolitan ties or suburban metropolitan, population 15,000 to 100,000. Interested in group or institutional practice. Eligible for specialty board examination June 1977. Contact Box P-11 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population 50,000 to 100,000. Prefers solo or small group practice. Eligible for specialty board examination July 1978. Contact Box P-12 c/o Ohio State Medical Journal.

UROLOGIST: Available July 1978. Desires community that is rural with metropolitan ties, suburban metropolitan or metropolitan. Population 50,000 to 500,000. Interested in solo or group practice. Eligible for specialty board examination May 1978. Contact Box P-13 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires location in areas 1, 2, 3 or 5 in suburban metropolitan or metropolitan community with population 50,000-500,000. Prefers group practice. Eligible for specialty board examination June 1978. Contact Box P-14 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires rural area with metropolitan ties, population 15,000-50,000. Prefers group practice of 6 or more members. Eligible for specialty board examination June 1978. Contact Box P-15 c/o Ohio State Medical Journal.

PEDIATRICIAN: Available July 1978. Desires location in areas 1, 2, or 5 in community that is rural with metropolitan ties or suburban metropolitan with population 15,000-50,000. Prefers small group practice. Eligible for specialty board examination May 1978. Contact Box P-16 c/o Ohio State Medical Journal.

DECEMBER 1977
Volume 73, Number 12
1977 Index

THE OHIO STATE Medical Journal



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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

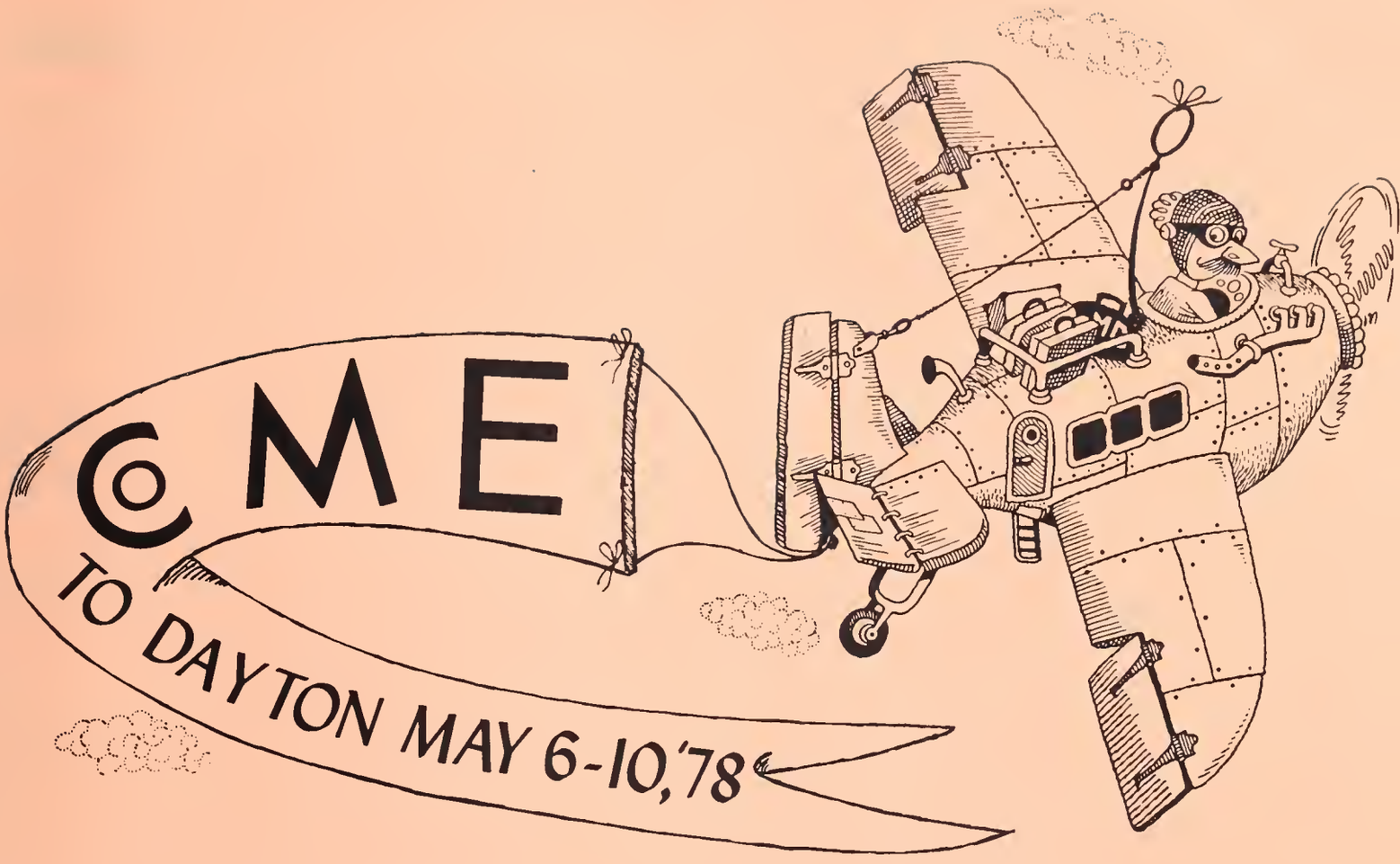
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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For further information contact: OSMA Department of Continuing Medical Education, 600 S. High St., Columbus 43215, phone: 614/228-6971.

Announcing . . .

The Ohio State Medical Journal Photographic Exhibit

The Ohio State Medical Journal is sponsoring a juried-and-judged photographic exhibit for members of the Ohio State Medical Association. The winning entries will receive awards at the 1978 OSMA Annual Meeting, where they also will be displayed. Winning entries may be published subsequently in *The Journal.*

Photographs may be entered in two divisions: (1) BLACK AND WHITE and (2) COLOR. Each division has eight categories: (1) Action, (2) Still, (3) Animals, (4) Scenic, (5) Portraits, (6) Scientific, (7) Special Effects, and (8) Miscellaneous.

Entries must be in print form (minimum size 8″ x 10″; maximum size 2′ x 3′) and must be previously unpublished. Right to publish the photograph must be given to *The Journal* at the time the photograph is entered in the exhibit. The print submitted for the exhibit will not be returned. Entries must be postmarked no later than February 15, 1978.

An OSMA member may submit as many entries as he/she wishes. Each entry must be accompanied by an entry form and a $5 entry fee.

Checks should be made payable to The Ohio State Medical Journal.

THE OHIO STATE MEDICAL JOURNAL PHOTOGRAPHIC EXHIBIT
ENTRY FORM

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STREET_____

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CATEGORY: Action____ Animals____ Portraits____ Special Effects____
Still____ Scenic____ Scientific____ Miscellaneous____

INFORMATION ABOUT PHOTOGRAPH (Provide as much as possible):

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Mail the photograph, entry form, and $5 entry fee **(make checks payable to The Ohio State Medical Journal)** to: The Ohio State Medical Journal Photographic Exhibit, 600 South High Street, Columbus, Ohio 43215.

Please be sure the photograph is securely wrapped to avoid bending.

(This Form May Be Duplicated)

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COVER: May the joys of childhood be with each of you this Holiday Season.

THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

The article on "Recognition and Management of Breast Cancer" (Vol. 73, No. 10, page 677) was very good.

The format was excellent. I am sure more articles of this nature would be most welcome.

Sincerely,
s/M. P. Smith, M.D.
Tiffin, Ohio

* * *

To the Editor:

I noticed in the *OSMA Journal* for September* a reference to the Buffalo, New York Health Systems Agency being the first, fully designated agency in the country. While this is correct, we, in Ohio, are proud to relate that the CORVA HSA in Cincinnati, Ohio, was designated at the same time. In fact, it is possible that CORVA may have been designated prior to the Buffalo agency; however, I wanted you to know that the CORVA agency was also included.

Sincerely,
s/Sewall Milliken, Chief
Office of Health Planning
Ohio Department of Health
Columbus, Ohio

*Vol. 73, No. 9, page 643.

* * *

To the Editor:

In 1977, a report entitled *Consumer Attitudes Toward Health Care and Medical Malpractice* was published under the sponsorship of the Ohio State Medical Association. This book and its abbreviated version, *Consumers Speak About Health Care,* were referred to in the "Report of the Task Force on Professional Liability," Vol. 73, No. 5, page 321 of *The Ohio State Medical Journal* (May 1977). Written by Roger D. Blackwell, Ph.D., and W. Wayne Talarzyk, Ph.D., professors of consumer behavior in the marketing department of The Ohio State University, the texts represent an exploration of the attitudes of Ohioans about health care in general and the specific issues surrounding the medical liability problem. It is gratifying that the OSMA has commissioned the study and made it available to Ohio physicians and others interested in medicolegal matters.

The study consisted of a telephone poll of 1,500 Ohioans selected from a stratified, random sample. It included questions about attitudes toward health care and the likelihood that respondents would initiate malpractice suits in certain hypothetical situations. Data obtained by this method are worthy of study, but their limitations must be recognized. Some people may express certain intentions to an interviewer but act differently at a time of decision. Others may give what they consider to be "right" or socially acceptable answers. It may be noted in this context that 89.5 percent of the respondents in the Blackwell and Talarzyk study answered affirmatively when asked, "Do you have a family doctor?" Those who have seen the case loads in our emergency rooms or are familiar with the difficulties many people have had finding personal physicians may question the meaning of this response. It might have been instructive to ask how many visits had been made to this physician in the past year, whether the doctor-patient relationship was solid enough to include regular preventive health care, and whether the relationship was with a single physician, a group, or an institutional outpatient service.

These considerations notwithstanding, the data demonstrate interesting trends and suggest areas for further action. The authors' concluding perspectives and this writer's comments on them are as follows:

1. "Health care by Ohio physicians is generally perceived to be of high quality." True, although a phenomenon was observed here that has been noted by others: people rate their own physician higher than they do the medical profession in general. Respondents judged their own physicians to be good or excellent 87.4 percent of the time, but rated the care given by doctors in general at that level only 58.7 percent of the time. These figures give the profession no cause for complacency.

2. "Patient-physician communication is the most important criteria (sic) in patient evaluation of physicians." The data confirmed the widely proclaimed importance of good communication between doctor and patient, listening to what the patient has to say and explaining diagnoses and treatment plans thoroughly. However, experi-

enced physicians know that the communication problem is more complex than it sometimes seems: some patients seek an inordinate amount of explanation or reassurance, a few are unable to comprehend what the doctor is saying, and certain medical problems are so complex that they defy attempts at adequate explanation to the layman. Realistically, the only solution seems to be continued efforts at communication and patient education combined with recognition by our critics that perfection in this area is impossible.

3. "The most frequent motivation for malpractice suits is perceived to be 'greediness' or the desire to 'get something for nothing.'" The statement is correct, but the data show a wide divergence of views on this issue. The medical profession appears to have substantial public sympathy for its position, but it is difficult to tell how much political value this has. Almost three-fourths of the respondents said they would support a law that lowered the proportion of settlement that lawyers could receive from malpractice suits, but it is uncertain how many of these people would actually attempt to influence their elected representatives toward this end. The medical and legal professions are perceived as being about equally responsible for malpractice suits: 21 percent of the respondents found doctors primarily responsible, and 20 percent put the blame mostly on lawyers.

4. "'The majority of people are not predisposed to bring a malpractice suit." It would appear from the data that no more than 30 percent of the population would sue even in the face of substantial evidence of malpractice. Although these 30 percent represent enough potential claimants to drive professional liability insurance rates to prohibitive levels, the data show how unrealistic are attempts by courts in some states to use lawsuits as a means of compensating patients who have suffered injury in the absence of malfeasance. More than two-thirds of the population would be barred from such compensation by their unwillingness to sue. Furthermore, other studies have shown that administrative costs (primarily legal fees) consume about 40 percent of the malpractice insurance dollar. Any health insurance system this inefficient would have been out of business long ago.

5. "Age, medical experience, and attitudes toward physicians are the best predictors of which individuals are likely to bring malpractice suits." The data show such trends, but they are not dramatic. The prototype of the suit-prone patient is one who is young, distrustful of physicians, eager for detailed explanations, and inclined to hold very liberal or very conservative political views. However, a significant number of respondents with other characteristics said they would sue under some circumstances. No population group was identified which was totally unwilling to file malpractice suits.

6. "There is substantial public support for selected solutions to the malpractice problem." Further investigation will be needed to determine whether this support goes beyond sympathy, whether it will be sustained in the face of opposition from the plaintiff's bar, and how much of the support can be utilized in the political arena.

The study of Blackwell and Talarzyk represents a significant contribution to our knowledge about public attitudes relevant to the malpractice insurance problem, but it would be unreasonable to expect more than this. It contains no easy solutions and is not a plan of action. However, the study does contribute data that will be helpful in planning ways to resolve the present medical liability crisis.

s/Robert D. Gillette, M.D.
Director, Riverside Family
Practice Center
Associate Professor,
Department of Family Medicine
Medical College of Ohio
Toledo, Ohio

The Journal *welcomes reader reaction to published material. Address correspondence: Editor,* **Ohio State Medical Journal,** *600 South High Street, Columbus, Ohio 43215.*



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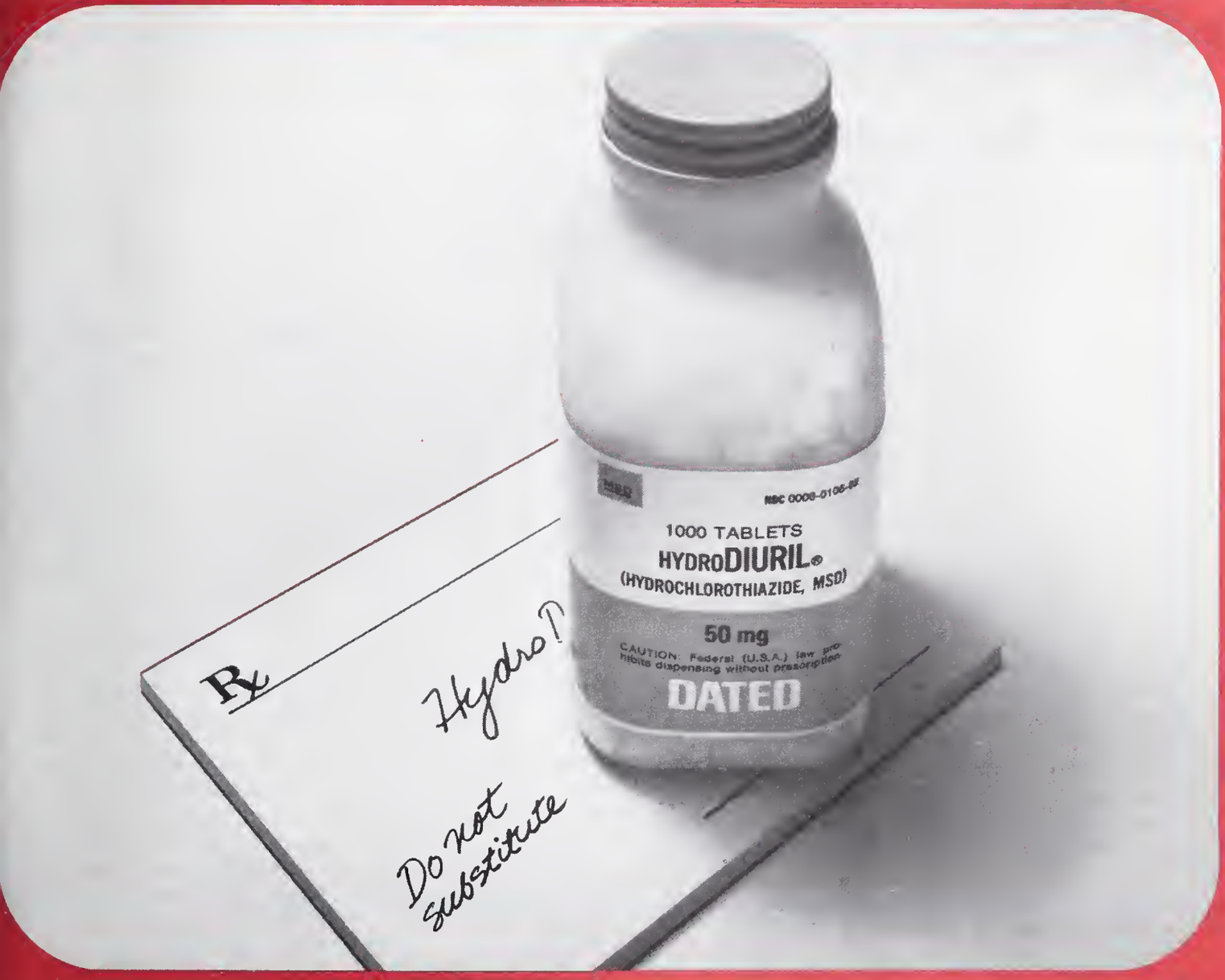
Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

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THE OHIO STATE Medical Association News

Humanities Study for Physicians

The National Endowment for the Humanities has announced continuation in 1978 of its program of humanities seminars for medical practitioners. From 12 to 15 persons will attend each seminar tuition-free, receiving a stipend of up to $1,200 to cover expenses plus reimbursement for travel. The seminars, which meet during the summer at selected colleges and universities, will bring physicians and other health professionals together for a month of full-time study under the direction of distinguished philosophers, historians, and other individuals.

The seminars are designed to give participants the opportunity to stand back from their work and to explore the humanistic dimensions of their profession by studying such topics as the history of professional ethics in American medicine, moral dilemmas in medical practice, and the relationship between individual and public rights in health care. A second series of seminars will deal with the ethical dimension in contemporary life, value conflict in our society, the cultural foundations of United States-Asian relations, individualism in American Society, and contemporary religious movements.

Physicians, nurses, public health officials, hospital administrators, and other health professionals may apply. The application deadline is tentatively set for April 17, 1978. Further information about the seminars, including application forms and selection of criteria, may be obtained from: Professions Program, Division of Fellowships, National Endowment for the Humanities, Washington, D.C. 20506.

Products Liability Study Includes Medical Devices and Equipment

A study of products liability law as applied to medical devices and equipment finds that while the number of lawsuits has increased substantially over the past two decades, the manufacturer has replaced the physician and hospital as the most often-cited cause of injury. In addition, the study found that though strict liability as legal grounds for recovery is gaining greatly, negligence as a legal argument remains the most frequently invoked plea.

This pioneering study, which analyzes 60 years of cases and whose broad findings are applicable to products of all types, was completed by Frost and Sullivan, Inc., a technological market research organization located in New York City.

The study discovered that the disposition of product liability cases remains evenly split between plaintiffs and defendants. However, most hurtful to defendants are the big damage awards that have increased sharply over the years. This increase is evident as follows:

Decade	Average Damages
1910-1919	...
1920-1929	$ 5,167
1930-1939	4,447
1940-1949	6,000
1950-1959	27,000
1960-1969	48,655
1970-	256,444

Frost and Sullivan found that the percentage of suits referring to a specific defect were: manufacturing— 47 percent; design— 32 percent; failure to warn— 25 percent; improper maintenance— 16 percent; improper inspection— 5 percent; contamination— 4 percent; and others— 8 percent. Among medical devices covered, 14 equipment categories generate the most litigation: anesthesia equipment, bone drills, catheters, crutches, electrosurgical equipment, hypothermia equipment, incubators, intrauterine devices, needles, orthopedic implants, pacemakers, pacifiers, vaporizers, and x-ray equipment.

Plaintiff lawyers have available three major theories of recovery on behalf of injured persons in product liability suits: negligence, breach of warranty, and strict liability. In addition, a plaintiff may also plead *res ipsa loquitur*— "the thing speaks for itself." This is particularly applicable when injury is inflicted on an unconcious patient and could not have occurred except for the negligence of a defendant.

Further information regarding this study may be obtained by contacting Customer Services, Frost and Sullivan, Inc., 106 Fulton Street, New York, New York 10038.

Medical School Accrediting Agency

The United States Office of Education has granted the Liaison Committee on Medical Education (LCME) recognition as the accrediting agency for medical schools for a two-year period. LCME's eligibility had been challenged in March 1977 by the Federal Trade Commission's Bureau of Competition on grounds of "potential" conflict of interest.

Am. Assoc. of Medical Assistants To Certify Twice Annually

Beginning in 1978, the Certifying Board of the American Association of Medical Assistants (AAMA) will offer certification examinations twice annually. These examinations will be given during the spring and winter at more than 150 test centers across the country. Currently, the National Board of Medical Examiners is working with the AAMA Certifying Board in Designing the 1978 certification examinations.

The AAMA offers these examinations as a service to both member and nonmember medical assistants. The 1978 spring examinations, including the Basic Examination and the Administrative and Clinical Specialties, will be offered on June 2, 1978 (registration deadline: January 15, 1978). The 1978 winter offering, consisting of only the Basic Examination, will be administered January 26, 1979 (registration deadline: October 1, 1978).

For further information, contact the AAMA Certifying Board, One East Wacker Drive, Chicago, Illinois 60601.

New Publication Devoted to "Firesafety in Hospitals"

The National Fire Protection Association (NFPA) has produced a new teaching package entitled "Firesafety in Hospitals." Designed to reduce the chance of hospital fires, the package provides information for administrators, engineers, safety directors, staff, and architects of hospitals. The package gives fundamental principles of firesafe operations in all hospital areas. "Action" points are stressed for employees to correct and/or report fire hazards wherever discovered. In addition, procedures are given for fire emergencies. The package (SL-24), which contains 79 35-mm slides, a cassette tape, an instructor's guide, and ten student workbooks, can be ordered for $65 from the NFPA Publications Sales Department, 470 Atlantic Avenue, Boston, Massachusetts 02210.

Medical Board Activity

The following is a list of activities and actions undertaken from October 1, 1977 to October 31, 1977 by the Ohio State Medical Board.

LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	34
	D.O.	8
Licensed by Examination	M.D.	1
	D.O.	0
Foreign Medical School Graduates		
Licensed by Endorsement		14
Licensed by Examination		0
Sept. 1972 FLEX Board Policy Licenses		4
Endorsements to Other States	M.D.	25
	D.O.	2

ENFORCEMENT ACTIVITY

Formal Citations Issued	1
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	5
Voluntary Surrenders of Medical Certificates	2
Arrests for Alleged Illegal Practice of Medicine	2
Formal Hearings on Alleged Violations of the Medical Practice Act	2

(News continued on page 804)

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Three Changes in Ohio Law Affect Physicians

D. Brent Mulgrew, Esq., and Richard A. Ayish, Director and Ass't. Director, OSMA Department of State Legislation

Drug Substitution

Ohio's statutory restriction on the substitution of a drug for another drug named on a physician's prescription will be repealed on January 1, 1978 as a result of the Ohio General Assembly having approved SB 45 in July. Members of the OSMA should be aware of the new law so that they can comply with its provisions.

The OSMA opposed the repeal of the antisubstitution law based upon the belief that a physician's choice and control of drug therapy is essential to the delivery of quality care. The strong support of organized labor, retail drug chains, and organized pharmacy pushed the bill through the General Assembly this year. The promoters of the measure predict a savings to the consumer of 40 to 50 percent per prescription and an overall cost saving in Ohio of as much as $50 million. Similar potential savings were touted when other states considered this legislation, but no states have realized consumer savings near these figures. The Ohio Legislature believed these claims and expects the new law to save consumers money.

Elements of SB 45

SB 45 repeals the present requirement that a pharmacist only dispense the specific product prescribed by the physician unless the change is approved in advance by the physician. The new law permits a pharmacist to substitute a "generically equivalent drug" if it has a lower retail price than the brand-name drug prescribed. The pharmacist may choose a "generally equivalent" product from a list based upon resource material he considers reliable. (This list may be developed by any pharmacist and should be reviewed by the physician dealing with the pharmacist.)

Before a pharmacist substitutes a "generically equivalent" product, he must inform the purchaser of the proposed substitution and indicate the amount of the "actual cost savings" between the brand name product and the generic drug dispensed.

The law requires a pharmacist who substitutes to indicate on the container's label "generic substitution made." This notice will remind the patient that the pharmacist made a substitution from the originally prescribed item.

The original version of SB 45 permitted a pharmacist to substitute the generic product of his choice for any prescription. With the support of the OSMA, the bill was amended to ensure that if the physician desires, he can have complete, nonsubstitutable control of drug therapy. The law permits the physician to require a pharmacist to dispense the specific product written on the patient's prescription **by writing in his own handwriting on the prescription form** "Dispense As Written" or "D.A.W." When this statement is written, the patient will receive only the product designated by the physician. If the prescription is given orally, the physician can limit substitution by orally restricting the pharmacist. These restrictions on substitution should be used if the physician believes it is important that the patient receive only the particular brand of drug prescribed. The physician who knows the patient's physiological balance and medical history is in the best position to decide whether or not to limit substitution.

SB 45 contains two important protections for physicians. The first relieves the physician from any civil or criminal liability from an incorrect substitution by a pharmacist for the named drug. The second states that a physician is not negligent for failure to write "D.A.W." on a prescription "unless the prescriber had **reasonable** cause to believe that the health condition of the patient for whom the drug was intended warranted the prescription of a specific brand name drug and no other." A physician cannot be held liable in a suit arising from the interchange of a "generically equivalent drug" for a prescribed drug unless the original prescription would have reasonably caused the same injury.

Keep Substitution in Mind When Prescribing

SB 45 does not eliminate the physician's responsibilities in the selection and prescription of appropriate drugs. The physician should remember that a pharmacist has the **option** to substitute a "generic equivalent" for the originally named product, unless the physician indicates on the prescription in his own handwriting "Dispense As Written" or "D.A.W." Every time a physician prescribes a multisource product, he should remember that a substitution could take place. While the pharmacist is not required to inform the physician of his substitution, many pharmacists have decided to do so nevertheless. If refills are requested, physicians should ask their patients whether or not the drug container carries the "Generic Substitution Made" notation indicating a pharmacist has substituted another product for the one originally prescribed, and properly amend the patient's record.

The first year of any law is a difficult period of transition. Many physicians already prescribe generically in appropriate cases, and physicians who believe that a

(continued on page 800)

contains no aspirin

tablets

Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



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700564

Ohio Law Changes *(continued)*

patient's health will not be compromised should permit generic substitution. However, if the physician believes it is appropriate to limit the option of substitution, he should write "Dispense As Written" or "D.A.W." on the prescription. As the pharmacist asserts a larger role in drug therapy, the patient needs to be reminded that the physician and the pharmacist are both working to deliver the highest quality health care at the lowest possible price.

If you have specific questions regarding SB 45, please write the OSMA Department of State Legislation, 600 South High Street, Columbus, Ohio 43215.

"Fictitious" Business Names

Effective November 24, 1977, the user of any business name which does not fully identify the user (ie, Doctors' Clinic) to report that name to the Secretary of State as a "Fictitious Name" unless it is on file as a corporate name or trade name. All names currently in use must be on file by December 31, 1978. Forms are available from the office of the Secretary of State for compliance with these requirements of Am. HB 296.

Users affected by the requirement include any individual doing business under a name other than his or her personal name, partnerships using a name that does not identify all the partners, corporations that do business under a name other than the corporate title, and other business entities using fictitious names.

The new law treats trade names and fictitious names as separate entities. A trade name is defined as "A name used in business . . . to *which the user asserts a right to exclusive use.*" (Emphasis added.) This filing, therefore, gives protection to the name against subsequent filings of confusingly similar corporate or trade names. A fictitious name is one which has not been or cannot be registered as a corporate or trade name (ie, because another has already so registered it). The fictitious name report gives no protection to the name. Its sole purpose is to comply with the law by making the use of the name a matter of public record.

The new law should make it easier for the public to determine with whom it is doing business and should aid attorneys in identifying the proper party to designate as defendant in many legal actions.

The filing fee for either registration is $10. The trade name fee is set by Section 1329.02 of the Revised Code, while the fee for fictitious name reports is based on Section 111.16 (F) of the Revised Code. Both types of filings are renewable at five-year intervals. The renewal fee for either report is $5.

Informed Consent

After the passage of the Medical Malpractice Act of 1975 (HB 682), many people misunderstood Section 2317.54 ORC. This section includes provision for an alternative statutory informed consent that would be presumed valid by a court. The advantage of the presumption of validity for the consent form was available to a physician whose consent form met the requirements of Section 2317.54 A, B, and C or was a copy of Section "D"— the statutory form.

Several hospitals in the Cincinnati area felt that the inclusion of the statutory form by the Legislature implied a mandate for its use. Although there have been no reported cases in Ohio holding a hospital liable for a physician's failure to get an informed consent from the patient prior to surgery, the hospitals wanted to be sure they were protected from potential liability in such a case. Therefore, they tried to mandate the use of the form in Section 2317.54 (D).

The disagreement between several hospitals and their physicians on the use of the statutory form led to the involvement of the OSMA and, finally, the Legislature. In an attempt to resolve this problem, HB 213 was introduced by Rep. Norman Murdock, Cincinnati, and Rep. Harry Lehman, Cleveland. These state legislators helped to get HB 213 enacted. The bill was signed by Governor Rhodes on August 25, 1977 and became effective November 24, 1977.

Repeal of Alternative Form

HB 213 repeals the alternative statutory form (Section D), thereby eliminating the belief that the Legislature originally meant to require the use of a written consent form or the statutory form in Section D. However, physicians who use a previously prepared consent form and want it to have a statutory presumption of validity must meet the requirements of Section 2317.54 A, B, and C:

Sec. 2317.54. A HOSPITAL SHALL NOT BE HELD LIABLE FOR A PHYSICIAN'S FAILURE TO OBTAIN AN INFORMED CONSENT FROM HIS PATIENT PRIOR TO A SURGICAL OR MEDICAL PROCEDURE OR COURSE OF PROCEDURES, UNLESS THE PHYSICIAN IS AN EMPLOYEE OF THE HOSPITAL.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills ~~either~~ all the requirements in divisions (A), (B), and (C) of this section ~~or the requirements of division (D) of this section~~, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, AND WHAT THE PROCEDURES ARE EXPECTED TO ACCOMPLISH, together with the REASONABLY known risks, AND, EXCEPT IN EMERGENCY SITUATIONS, SETS FORTH THE NAMES OF THE PHYSICIANS WHO SHALL PERFORM THE INTENDED SURGICAL PROCEDURES ~~if any, of death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars, associated with such~~

~~procedure or procedures, with the probability of each such risk of reasonably determinable.~~

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

Since the types of medical practice vary widely, each physician should consult his or her own legal counsel for advice as to whether a written consent form following the statutory format should be used.

Liability of Hospital

The issue of a hospital's potential liability for an independent (private) physician's failure to get a patient's consent is also resolved by HB 213. The law states: "A hospital shall not be held liable for a physician's failure to obtain informed consent from his patient prior to a surgical or medical procedure, or course of procedures, *unless* the physician is an employee of the hospital" (2317.54 ORC). This section establishes the hospital's responsibility for ensuring that its employed physicians obtain an informed consent from patients. Although the section establishes the hospital's responsibility, the section does not require the use of a particular form or format.

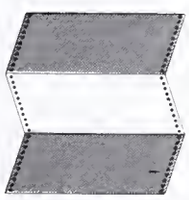
Section 2317.54 (A) also requires the disclosure of the nature and purpose of the procedures— what the procedures are intended to accomplish— together with the reasonably known risks. The Legislature repealed the so-called laundry list of potential risks and replaced it with the requirement that if the statutory form is used, it include those risks reasonably known. The new law also requires that a form meeting the statutory requirements must disclose, "except in emergency situations," the names of the physicians who will do the "surgical procedures."

HB 213 does not eliminate the physician's responsibility to discuss with the patient a proposed procedure and its risks in terms the patient can understand. The use of any consent form, including one that meets the requirements of 2317.54 A, B, and C, serves only as written documentation that the discussion between physician and patient took place. A completed consent form can be used to substantiate that the discussion occurred and that the patient understood what was explained, but the discussion between physician and patient, not simply the completion of a consent form, is the best defense to a claim by the patient that he or she had not given a valid informed consent.

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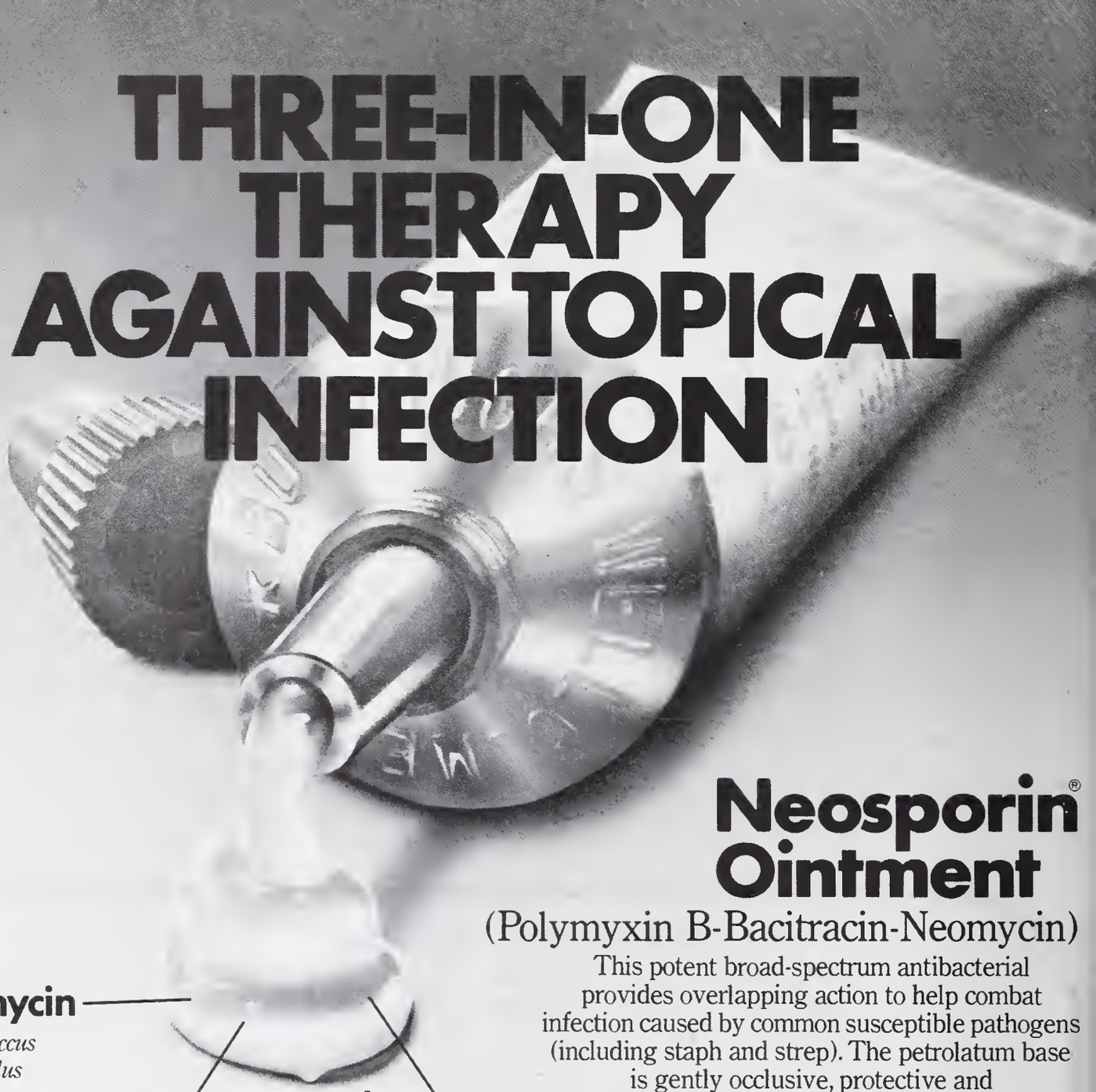
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Neomycin

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Pneumococcus

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Staphylococcus
Corynebacterium
Streptococcus
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Colleagues in the News

WILLIAM A. ALTEMEIER, M.D., Chairman of the Department of Surgery at the University of Cincinnati College of Medicine for 25 years, has been elected President-Elect of the American College of Surgeons (ACS). Internationally known for his work on surgical infection and shock and trauma, Dr. Altemeier joined the University of Cincinnati medical faculty in 1940. In 1952, he was named department chairman and the Christian R. Holmes Professor of Surgery. One of Dr. Altemeier's accomplishments on the local scene is the conception and development of the Surgical Research Unit at the College of Medicine. The numerous research projects of the surgery department are concentrated in this unit.

The ACS gave Dr. Altemeier its Distinguished Service Award in 1975. He has been a member of the American College of Surgery's Board of Governors and was chairman of the editorial committee for the ACS *Manual on Control of Infections in Surgical Patients*. In 1977, Dr. Altemeier was honored by the Royal College of Surgeons of England when he was made an Honorary Fellow. Dr. Altemeier's other activities have included the presidencies of the American Surgical Association, the Society for Surgery of the Alimentary Tract, the Society for Clinical Surgery, and the Cincinnati Surgical Society.

A native of Cincinnati and a graduate of the University of Cincinnati College of Medicine, Dr. Altemeier will be installed as President of the American College of Surgeons in October 1978.

SHARAD D. DEODHAR, M.D., Head of the Department of Immunopathology at the Cleveland Clinic, has been appointed to a three-year term on the Immunology Committee of the Food and Drug Administration (FDA). The nine-person committee was formed about three years ago to advise the FDA concerning any food or drug products that may affect the human body's immunologic defense system. Dr. Deodhar resides in Cleveland Heights.

JOHN H. DIRCKX, M.D., Dayton, is the author of a recently released text entitled *A Physician's Guide to Medical Writing,* published by G. K. Hall & Co., Boston. The book was written specifically for physicians who need to write technical papers but have little or no experience in writing for publication. It deals with the problems that confront the inexperienced writer and provides specific guidelines for preparing technical material for publication. Dr. Dirckx is Medical Director of the Student Health Center, University of Dayton. He is also the author of *The Language of Medicine.*

JOHN C. ELDER, M.D., Cleveland, has assumed the directorship of the Department of Medicine of Huron Road Hospital. A member of the hospital staff since 1957, Dr. Elder fills the vacancy left by **MICHAEL HANNA, M.D.,** who entered private practice. Dr. Elder is certified by the board of American College of Physicians.

COLONEL CHARLES H. EVANS, JR., Findlay, has been awarded the Ohio Commendation Medal. Corps Surgeon of the Ohio Defense Corps, Col. Evans received the award for exceptionally meritorious achievement. An accompanying citation read in part:

> At great, repeated and willing sacrifice of his personal time, finances and commitment to his civilian profession, he has made major contributions of his professional expertise and military leadership to the Ohio Defense Corps. . . . His superior performance beyond the strictest interpretation of his obligations has inspired others and has reflected credit upon himself, the Ohio Defense Corps, and the State of Ohio.

CHARLES M. GREENWALD, M.D., has been elected president of the Cleveland Radiological Society for the year 1977-1978. The other officers are **BENJAMIN KAUFMAN, M.D.,** president-elect; **JOHN B. McCOY, M.D.,** secretary-treasurer; and **HARRY GAZELLE, M.D.,** member-at-large.

ROBERT T. MURPHY, M.D., Cleveland, has been named Director of the Department of Surgery of Huron Road Hospital. He succeeds **M. D. RAM, M.D.** Dr. Murphy, who joined the hospital staff in 1958, is a Fellow of the American College of Surgeons.

HOMER SCHROEDER, M.D., Toledo, has been elected to the Board of Directors of Toastmasters International. Dr. Schroeder is Director of Education in the Obstetrics/Gynecology Department of Mercy Hospital.

FRANK J. WEINSTOCK, M.D., Canton, has been presented an Honor Award by the American Academy of Ophthalmology and Otolaryngology. This award recognizes Dr. Weinstock for teaching services on behalf of the Academy.

"Colleagues in the News" is sponsored by

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News *(continued from page 797)*

V.A. Health and Medical Programs

About 200,000 dependents and survivors of veterans have established eligibility for Civilian Health and Medical Programs of the Veterans Administration (CHAMPVA). Similar to the civilian health care program (CHAMPUS) offered by the Defense Department, CHAMPVA is a cost-sharing program. It pays a share of the usual and customary charges for approved health-care services from private physicians, community hospitals, or other authorized providers of care.

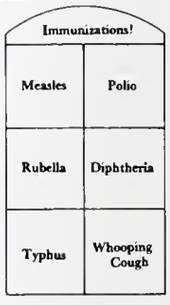
Eligibility for CHAMPVA is limited to spouses and children of veterans with a service-connected, total disability which is permanent in nature. Also eligible are surviving spouses and children of a veteran who died as a result of a service-connected disability or at the time of death had a service-connected total disability, permanent in nature. Excepted are dependents and survivors of veterans who are eligible for CHAMPUS or Medicare.

CHAMPVA pays 75 percent of the reasonable charges of the hospital and professional personnel for authorized inpatient care. For outpatient care, the first $50 is paid by the beneficiary each fiscal year. When claims are submitted for two or more beneficiaries of a family, the deductible is $100. After the deductible is paid, CHAMPVA pays 75 percent of the remaining reasonable charges, with the family member paying the balance.

Application for CHAMPVA benefits should be made to the nearest Veterans Administration hospital or outpatient clinic.

AMA Auxiliary Focuses on Immunization of Children

New graffiti have begun appearing on the pavements of school playgrounds across the country. But it is a bit different from the usual, for physicians' wives are painting specially designed hopscotch courts which are intended to alert children to the need for immunization.



The stencil painting is an outgrowth of an AMA public service television campaign which uses children playing hopscotch as a theme. In addition to public service announcements, the campaign includes a filmed puppet show featuring mock sinister characters, each representing a different disease.

Mrs. Chester Young, President of the AMA Auxiliary, whose members are doing the painting, said: "This

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Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
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Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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generation of young parents grew up free of the fear of epidemics of polio and of other childhood diseases, like measles, because their parents knew the ravages of the diseases. So young people just haven't been getting their children immunized the way they should. The idea of our campaign is to break through their apathy and remind young parents of their responsibility to protect their children against disease."

Mrs. Young pointed out that 40 percent of all American children under 15 years of age are not properly immunized.

The campaign is directed at children and, through them, their parents. Auxiliary members are organized in 1,500 counties in the United States, and the AMA has provided the hopscotch stencils to each chapter. The women will concentrate on grammar schools.

Clinic Construction Cost Booklet

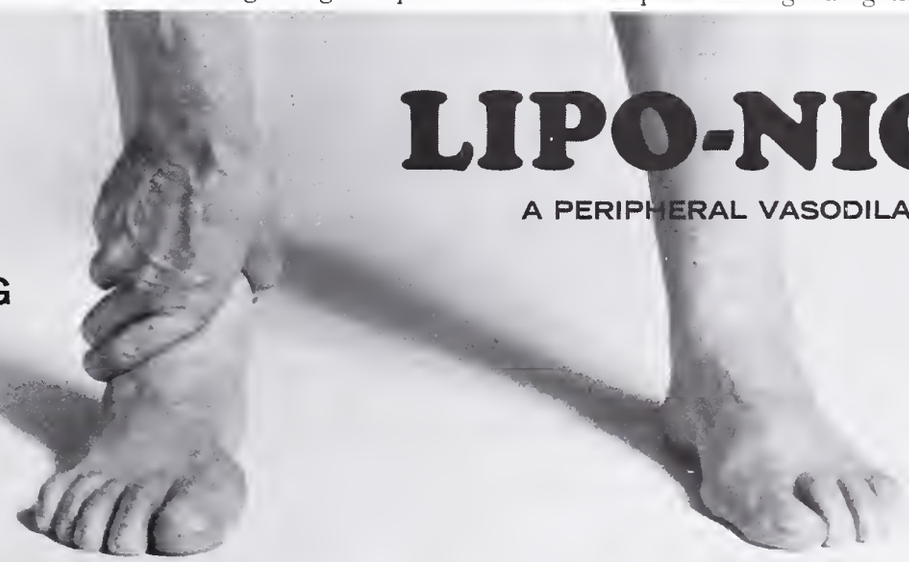
The Appalachian Regional Commission (ARC) has prepared a pamphlet designed to present guidelines for construction of functional and cost-effective buildings. Written for small rural clinics, "Primary Care Centers, Design and Construction" follows the development of a primary care center from early planning and budgeting to design and construction of the building. Single copies are available at no cost through the office of Nancy Lane, ARC, 1666 Connecticut Avenue, N.W., Washington D.C. 20235.

Pick Your Best And Enter The Journal Photography Exhibit

OSMA members are encouraged to enter *The Ohio State Medical Journal* Photographic Exhibit, which will be displayed during the 1978 OSMA Annual Meeting. In addition to being displayed, winning entries will receive awards during the second session of the House of Delegates. An entry form for the exhibit appears as page 790 of this issue.

Members of the committee overseeing this exhibit are Harry K. Hines, M.D., Chairman, Cincinnati; Theodore J. Castele, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; Kathryn P. Clausen, M.D., Columbus; James C. McLarnan, M.D., Mt. Vernon; Richard L. Meiling, M.D., Consulting Medical Editor of *The Journal;* D. Brent Mulgrew, Esq., Director of the OSMA Department of State Legislation; and Linda A. Porterfield, Executive Editor of *The Journal.* Any of these persons will be happy to answer questions regarding the exhibit.

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Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Ohio Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

January 1978

PHYSIOLOGY OF ENDOCRINE SURGERY— PART II: January 5; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

WHERE THE HEALTH DEPARTMENT FITS IN THE COMMUNITY: January 5; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

IMPOTENCE: January 7; Saint Anthony Hospital, Columbus; 1 credit hour; contact: Philip B. Hardymon, M.D., Director of Medical Education, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus 43203, phone: 614/253-8877.

COMMON SURGICAL PROBLEMS AND THEIR MANAGEMENT: January 11 and 12; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150, $75 students and residents; contact: Penn G. Skillern, M.D., Center for Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NUTRITIONAL SUPPORT OF THE SICK PREMATURE: January 11-12; Dayton Downtown Sheraton Hotel; contact: D. Methven Cathro, M.D., President, Western Ohio Pediatric Society, 1735 Chapel Street, Dayton 45404, phone: 513/461-4790.

NUCLEAR MEDICINE ULTRASOUND COMPUTERIZED TOMOGRAPHY IN MEDICAL PRACTICE, 1978: January 11-14; Disneyland Hotel, Anaheim, California; cosponsor: Nuclear Medicine Institute, Cleveland; 27 hours credit; fees vary; contact: Nuclear Medicine Institute, 6780 Mayfield Road, Cleveland 44124, phone: 216/449-4500, ext. 370.

THE OHIO STATE MEDICAL BOARD: ITS PHILOSOPHY AND FUNCTION: January 12; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, 614/383-6301, ext. 292.

FAMILY MEDICINE WORKSHOP: January 14-15, 28-29; Hospitality Motor Inn, Columbus; sponsor: Ohio Academy of Family Physicians; 12 credit hours each weekend; fee per weekend: $75 members, $125 nonmembers; contact: Gail W. Burrier, M.D., Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

NEUROLOGY OF MICTURITION: January 17; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary or Ms. Karen Saslaw, Education Coordinator, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

NEURO-URODYNAMICS: January 17; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Educational Coordinator, Riverside Methodist Hospital; 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

SURGICAL MANAGEMENT OF ENDOCRINE DISORDERS—PART I: January 19; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

CONTROL OF PANCREATIC HORMONES AND TREATMENT OF SEVERE ALCOHOLIC LIVER DISEASE: January 24, 7:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Education Coordinator, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

INFLAMMATORY BOWEL DISEASE IN THE LIVER: January 24, 8:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Education Coordinator, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

DIABETES MELLITUS AND HYPERTENSIVE DISORDERS ASSOCIATED WITH PREGNANCY: January 25, 8:30 AM; Cleveland Metropolitan General Hospital, Cleveland; 7 credit hours; contact: M. Rosen, M.D., Department of Obstetrics and Gynecology, Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109, phone: 216/398-6000.

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: January 25 and 26; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $90, $45 residents and students; contact: Penn G. Skillern, M.D., Center for Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106; phone: 216/444-5696.

February 1978

A PRACTICAL APPROACH TO COMMON PROBLEMS IN KIDNEY DISEASE AND HYPERTENSION: February 1-2; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

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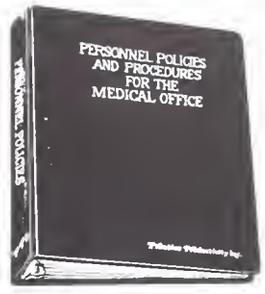
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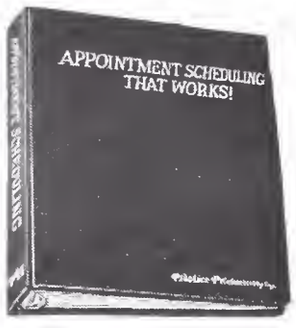
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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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Indications—Relief of symptoms of anxiety and depression.

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Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

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Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

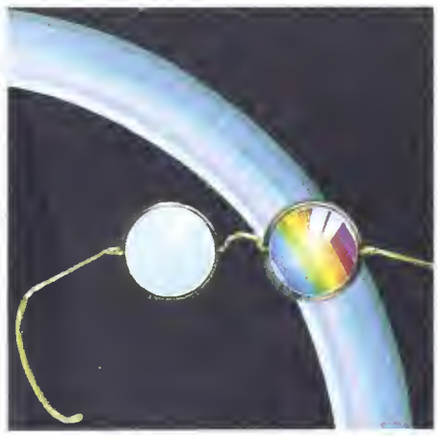
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

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Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Co the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pen and counted upon to benefit 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the me "the cornerstone in a stru which is being built but is mer's comple

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SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

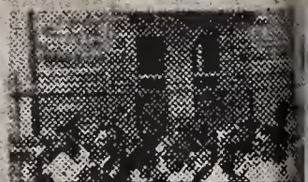
"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

IGNE the Draf Ends No



WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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THE OHIO STATE Medical Association Clinical and Scientific

Kaposi's Sarcoma
A Clinical Study in Ohio

David B. Stoll
John H. Hughes, M.D.
Kitai Kim, M.D.

Kaposi's sarcoma is a rare and frequently misdiagnosed disorder, and often is omitted in discussion of soft tissue sarcomas. Six previously unreported instances of Kaposi's sarcoma from the State of Ohio are presented. A survey of cases recently reported in the United States also is presented. Acceptable recent methods of treatment, current theories of genesis, and cause of the disorder are discussed.

WHILE KAPOSI'S SARCOMA is seen commonly in Africa, its occurrence in the United States is rare. Since this disease entity may be unrecognized or unreported and since it may offer clues to the basic understanding of cancer, we have collected cases reported throughout Ohio and have reviewed the cases recently reported in the United States. In June 1976, we sent 265 letters to pathologists throughout Ohio requesting information on unreported cases of Kaposi's sarcoma in Ohio in recent years. Fifteen pathologists have responded so far, and we have collected data on six cases.

Clinical Data

Patient 1. In 1971, a 90-year-old white man was admitted to a hospital in Ohio for a large, pedunculated lesion which was excised from the right elbow and subsequently diagnosed as Kaposi's sarcoma. A year later, he developed similar, nodular, fungating lesions in the right, small finger and the dorsum of the right wrist. Excisional biopsies of the lesions revealed Kaposi's sarcoma. In 1973, the patient was admitted for a large, raised, fungating lesion of the left hypothenar eminence of the hand which showed Kaposi's sarcoma. It was treated by complete excision. As of 1976, there has been no recurrent disease.

Patient 2. A 48-year-old white man was admitted to a hospital in 1961 for treatment of a lesion of the great toe of the right foot. Excision revealed Kaposi's sarcoma. The patient was well until 1974, at which time nodular lesions on the right, inferior hemothorax appeared. Following excision, which revealed Kaposi's sarcoma, the patient underwent radiation therapy to the affected area. In 1976, similar lesions were noted on the right-lower chest and abdominal wall which were excised. To date, he has had no further complications or recurrences.

Patient 3. A 75-year-old white man was admitted to the hospital for recurrent hemoptysis. A few weeks prior to admission, the patient had developed a protruding hematoma in the left tarsal area without associated trauma, a small, tender, bluish plaque over the right acromioclavicular area, and similar lesions over the left-fifth tarsophalangeal area. Biopsy of the skin lesions revealed atypical, angioblastic proliferation suggestive of Kaposi's sarcoma. Bronchoscopy revealed bleeding from the left-upper lobe. A tissue diagnosis was not obtained. The patient subsequently underwent therapy to both the chest and the involved skin areas. He died 1½ years later, but permission was not granted for an autopsy.

Patient 4. A 78-year-old white woman was admitted to the hospital in 1961. She had been hypertensive and, on admission, had massive edema in both legs and micocytic anemia with a hemoglobin value of 8.0 gm/100 ml.

This study was made possible by a student fellowship grant from the Ohio Division of the American Cancer Society.
A list of the references can be obtained from Mr. Stoll at 1106½ Newbury Street, Toledo, Ohio 43609.
Mr. Stoll, Toledo, undergraduate medical student, Medical College of Ohio at Toledo.
Dr. Hughes, formerly of Toledo, currently Associate Professor of Surgery, University of Arizona School of Medicine, Tucson.
Dr. Kim, Toledo, Assistant Professor of Pathology, Medical College of Ohio at Toledo.
Submitted March 18, 1977.

In the course of her medical therapy, a biopsy of the purpuric lesions of the legs showed typical findings of Kaposi's sarcoma.

While receiving medical care for the anemia and edema, the patient developed pulmonary congestion, abdominal pain and vomiting, and showed signs of a cerebral vascular accident. She died 25 days later, and request for autopsy was denied.

Patient 5. A 77-year-old white man, with no complaints other than a 1.0-cm, raised, gray-tan lesion on the heel, was hospitalized in April 1971. Examination revealed a rounded nodule covered by intact skin. The pathologic diagnosis was Kaposi's sarcoma.

The patient was seen again on the following January for nodules of a pinkish color on the foot. Histologic sections of the lesions revealed Kaposi's sarcoma. In April, he presented with multiple, red, hemangioma-like lesions on the middle of the right foot. Biopsy of the lesions revealed Kaposi's sarcoma. A 1.2-cm, purplish-blue-tan nodule removed from the right foot 19 months later had similar characteristics and again was diagnosed as Kaposi's sarcoma. In all of these instances, the treatment was surgical excision of the nodule(s). There were no other associated complaints reported with the foregoing instances. In May 1974, five more sarcomas were excised from this patient's feet. To date, he has had no recurrences of the disease.

Patient 6. A 62-year-old white woman was seen in March 1971 with a pale-reddish-blue, nodular, bleeding, skin lesion. It was 0.6 cm in diameter on the dorsal aspect of the fifth metatarsal joint of the right foot. Excisional biopsy revealed Kaposi's sarcoma. On September 5, 1976, a recurring lesion of the disease was excised. The patient has been asymptomatic since.

Pathologic Findings

These neoplasms are bluish-tan or dark brown nodules or occasionally well-circumscribed plaques, ranging from 0.5 cm to 1.5 cm in greatest dimension, and occurring most often in the distal portion of the extremities. They may be a single lesion and subsequently recur locally or in other areas.

Histopathologic findings of the neoplasms involve the dermal layer with a fairly well defined, compact, cellular mass separated by a narrow subepidermal layer from the overlying epidermis (Figs. 1 and 2). The overlying epidermal layer usually is intact, however, focal or diffuse ulceration may occur. They are composed of irregular fascicles of intertwining and intercommunicating spindle-shaped cells with hyperemic vascular slits (Fig. 3). Red blood cells in the vascular slits and extravascular areas are prominent (Fig. 4). The neoplastic cells are elongated and fusiform with indistinct cytoplasmic borders. The nuclei are fusiform and spindle-shaped, and hyperchromatic with coarse chromatin clumps (Figs. 5, 6, and 7). Mitotic figures are seen rarely.

There is no prominent cytologic difference of the neoplastic cells between those of endothelial cell, peri-

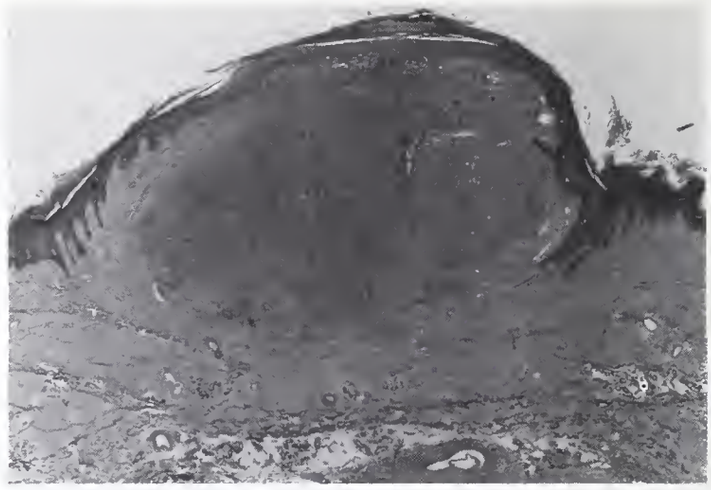


Fig. 1. Well-defined, nodular, neoplastic mass in dermis separated from overlying epidermis. Dome-shaped lesion.

cytic, or fibroblastic origin in compact areas of the neoplasm. The neoplastic cells arising from two different sources may proliferate into similar cell types as the neoplasm grows.

The differential diagnosis of Kaposi's sarcoma should include the following:

(A) *Malignant Hemangioendothelioma:* Prominent here are freely anastomosing, vascular channels lined by distinct and bizarre endothelial cells. Intervening fibroblastic atypia is not prominent.

(B) *Fibrosarcoma:* This is characterized by interlacing, atypical, fibroblastic bundles with frequent mitotic figures. There are no vascular slits containing erythrocytes, as is characteristic of Kaposi's sarcoma.

(C) *Dermatofibrosarcoma Protuberans:* This often appears as a subcutaneous nodule. Histologically, it is characterized by a compact, whorled, storiform pattern.



Fig. 2. Polypoid neoplastic mass, apparently pushing toward skin surface, rather than infiltrating into underlying tissue.

Occasionally, the cells are atypical with mitotic figures, however, vascular slits are absent.

(D) *Sclerosing Hemangioma (Dermatofibroma):* This presents with a histologic arrangement of small capillary lumens that is similar to Kaposi's sarcoma. In dermatofibroma, there are quite prominent collagen components in the intervening areas. Cellular atypia and vascular slits containing red blood cells are not present with dermatofibroma.

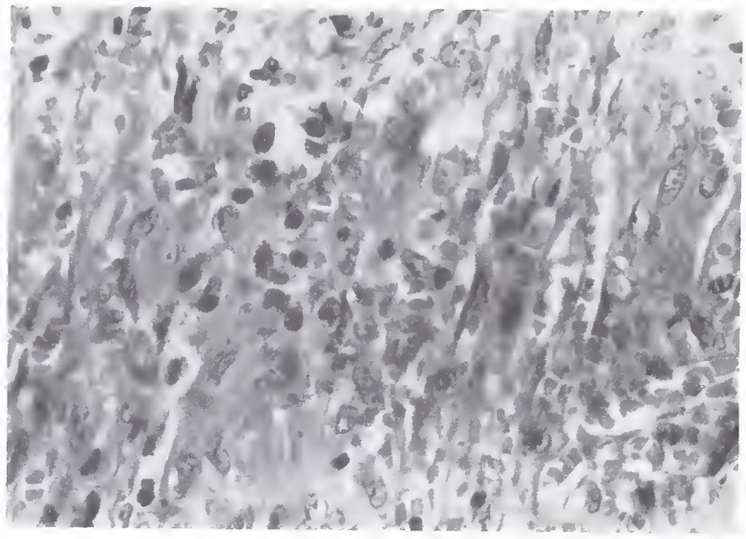


FIG. 4. Prominent vascular slit containing red blood cells in interlacing neoplastic cell mass.

Discussion

Kaposi's sarcoma was first described by Moricz Kaposi, in 1872, as "idiopathic multiple pigmented sarcomas of the skin."[1] Subsequent studies have suggested that the neoplasm arises in cells of hemangioreticuloendothelial origin, most likely the pericytes and endothelial cells.[2]

International variation in incidence is impressive. In Uganda, it is responsible for 9 percent of the malignant tumors in males and in only 0.6 percent of the malignant tumors in females.[3] Among the Bantu of Mozambique, it is felt to account for about 2 percent of all tumors of both sexes, with an incidence of 2.2/10,000 people per year and an adjusted sex ratio of 3.5 males to 1.0 females.[4] The South African Institute for Medical Research reported 66 of 15,000 cancers registered there between 1949 and 1953 were Kaposi's sarcoma.[5] A study from the University of Chicago reported eight cases of Kaposi's sarcoma out of 13,700 malignancies reported there from 1946 to 1960.[6] There is an apparent increase in the incidence of this disease entity in immigrants to the United States from Eastern Europe and Italy[7] and increased incidence in Jews.[8]

While common in blacks in Africa, this disease appears to be rare in blacks in the United States. The incidence in white males in the United States is greater than

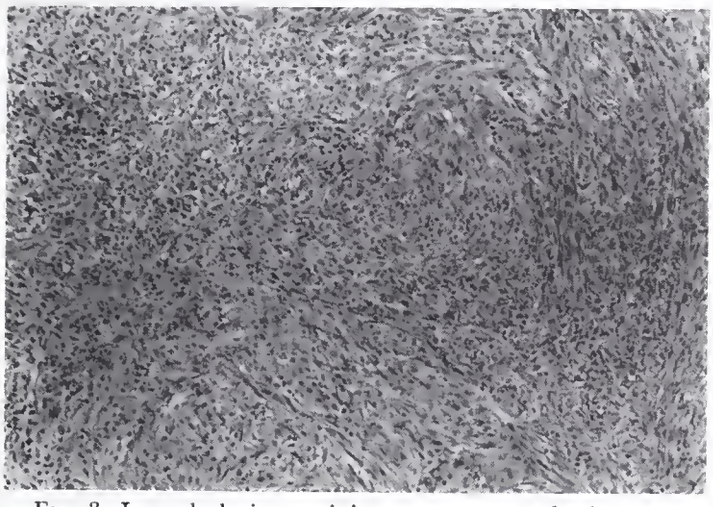


FIG. 3. Irregularly intertwining compact neoplastic mass.

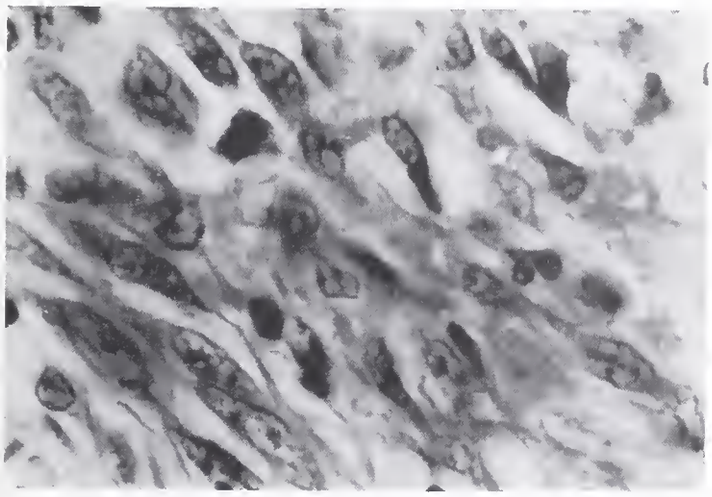


FIG. 5. Fusiform and spindle-shaped neoplastic cells. Abnormal mitotic figures are rarely seen.

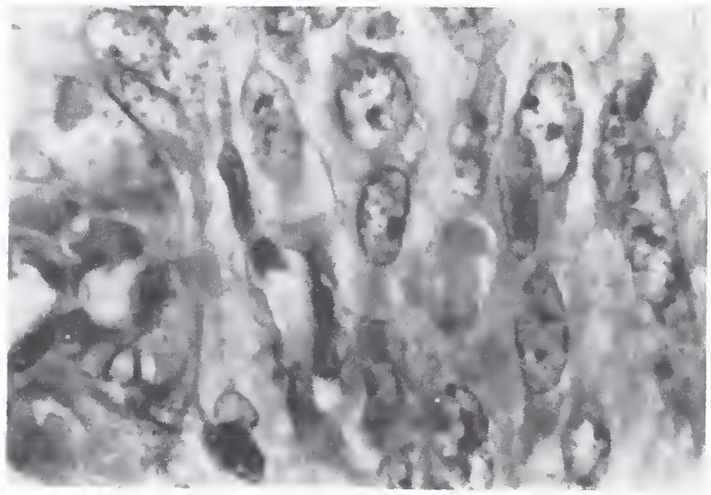


FIG. 6. Hyperchromatic nuclei with coarse chromatin clumps.

in white females.[9] Brasfield and O'Brien from New York reported a male-female ratio of 4.25:1.0.[10]

To date, no occupational or environmental carcinogens have been associated with this tumor. Some factors of similarity have been noted in both Kaposi's sarcoma and Burkitt's lymphoma.[11] High incidence is seen in similar areas of Africa. Both tumors are found in sites which possess sparse lymphoid tissue;[12] both tumors generally exhibit recurrence at different sites, with a poor prognosis when lymph-node involvement is found.[13,14]

Increase in susceptibility to Kaposi's sarcoma may be associated with diseases of the lymphatic systems. For example, of 1,200 cases of Kaposi's sarcoma in the literature, 1 percent were associated with Hodgkin's disease, whereas the incidence of Hodgkin's disease in the general population is .002 percent.[11] Cox and Helwig[7] reported three cases of lymphoma among 50 patients with Kaposi's sarcoma; Reynolds, et al[15] reported 4 out of 70; and O'Brien and Brasfield[16] reported 8 out of 68. Association of the disorder with plasma cell dyscrasia,[17] lymphosarcoma,[18] multiple myeloma,[19] polymyositis,[20] systemic erythematosus,[21] and in kidney transplant patients have been noted. In the latter two reports, the subjects were receiving immunosuppressive therapy. Other lymphatic diseases associated include Hodgkin's disease, mycosis fungoides, and lymphocytic lymphoma with or without leukemia.[22]

While skin and lymph node involvement is most common, visceral lesions may be found. Gastrointestinal involvement is the most common of visceral forms, with any organ of the digestive tract being involved.[22] The mucous membrane lesions may involve the mouth, throat, genitalia, and conjunctiva; and the neoplasm also may spread to the respiratory system.[23] Mortality may be associated with hemorrhage from the lesions in the gastrointestinal tract on concomitant infections.[24] Extensive cutaneous dissemination, severe infiltration, and ulceration of lower extremities may be seen. Nodules may regress spontaneously and frequently are accompanied by nonpitting, local edema. Cutaneous lesions have a proclivity for the bony prominences of the feet, ankles, knees, and hands.

Clinically, Taylor, et al[25] use the classification of (A) nodular — usually benign in its course and associated with involvement of the extremities; (B) florid-ulcerative — rapid in its spread; (C) infiltrative — involving dermis and later bone; and (D) lymphadenopathic — extremely disseminated. The childhood form of the last stage is characterized by widespread lymph node enlargement and a poor prognosis.[26]

Other Recently Reported Cases in the United States

As this disease entity is rare and highly variable, the Table was developed to list other recent cases of Kaposi's sarcoma reported in the United States. The general descriptive characteristics of the disorder conform to those summarized in this table and are included to further its elucidation. Since the extent of operative

Selected Cases of Kaposi's Sarcoma Reported in the Literature (U.S.A. Only) 1973-1975

Author	Reference No.	Age	Sex	Race or Nationality	Tumor Location	Treatment
Howard	43	75	M	White	Bulbar, conjunctiva, both legs	Radiation
Ettinger	19	62	F	Black	Right foot, lower leg	Radiation, excision
Ahmed	44	68	M	Latin American	Both feet, right groin, right thigh, body of the stomach	Chemotherapy
		60	M	White	Body of the stomach and fundus	Chemotherapy
		77	M	White	Body of the stomach	Chemotherapy
		65	M	White	Skin, body and fundus of the stomach	Chemotherapy
Law	17	74	M	White	Face and lower extremities	Chemotherapy
Rothman	31	64	M		Right foot	Radiation
		61	F		Hard palate, left foot	Radiation
		90	M	Puerto Rican	Right thigh	Radiation
		83	F	Puerto Rican	Right leg	Radiation
		82	M		Right leg	Radiation
		62	M		Left groin, occipital, and pre-auricular areas	Excision and radiation
		74	M		Lip, palate, buccal mucosa, scalp, and forearm	
Lanzotti	32	68	M		Groin, lumen of stomach, and duodenum	Chemotherapy
		64	M		Left ankle, lower extremities	Chemotherapy
Baxt	45	23	M	White	Left palm and long finger	Radiation
Gambardella	46	71	M	White	Tongue, feet and toes, glans penis	Radiation
Girgis	47	72	M	White	Glans penis	Surgery
Dantzig	20	60	M	Black	Arms and legs	
Klein	21	37	F	Puerto Rican	Left arm, both thighs	Radiation

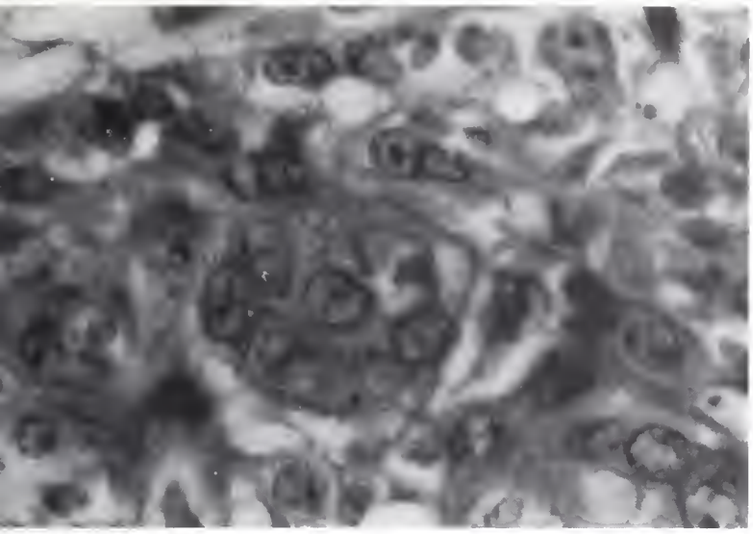


FIG. 7. Cross section of compact fascicle. Neoplastic fibroblasts and endothelial cells are indistinguishable from each other.

therapy, method of radiotherapy, and protocol for chemotherapy chosen in each case were highly variable, the reader is referred to the individual case reports. Some other recent reviews are those by Feurman, et al,[27] Mann,[28] Brownstein, et al,[29] and Templeton.[30] It appears that significant improvement in the detection and evaluation of this disease has been aided by Technetium 99 scanning techniques.[31] When lesions are well circumscribed, wide local excision appears to be curative. For disseminated disease, a variety of chemotherapeutic regimens have been tried with the combination of doxorubicin, dacarbazine, and vincristine sulfate showing some success.[32] Actinomycin D in combination with vincristine has proved helpful,[33] as has imidazole carboxanide.[34]

Evidence for viral involvement in this disease comes from work by Geraldo, et al[35,36] where, in cases of Kaposi's sarcoma from Zaire and Uganda, herpes virus was observed in association with antigens common to cytomegalovirus (CMV) and Epstein-Barr virus (EB-v). This led to the proposition that a new herpes simplex virus carrying antigenic determinants of both cytomegalovirus and Epstein-Barr virus was involved in the pathogenesis of this disorder. Further work[37] reported an increased incidence of high anti-CMV antigen titres in cases of Kaposi's sarcoma in Europe, but not in those in Africa. An additional causative mechanism, propounded by Warner and O'Laughlin,[12] suggests that in an immunologically deficient host, a reaction between antigenically transformed lymphoid cells and normal lymphocytes could result in the reduction of an angiogenesis factor with concomitant and oncongenic viral transmission to the affected cells and subsequent neoplasia. A proposed tumor angiogenic factor, elucidated by Folkman,[38,39] and further substantiated by co-workers,[40,41] has been suggested to be involved in angiomatous disorders like Kaposi's sarcoma.[42] However, its direct involvement is unclarified and tenuous at present.

Summary

Kaposi's sarcoma is a tumor rarely found in the United States although it is more common in Africa. Its presenting characteristics are highly variable. It appears to be associated with patients with immunodeficiency disorders. Recent cases reported in the United States are reviewed, and six previously unreported cases from Ohio are presented.* The epidemiologic and pathologic characteristics of the disease are reviewed. Possible viral involvement in the pathogenesis of this disease and the postulated involvement of angiogenic factor are noted.

Acknowledgement: The following physicians and hospitals provided information regarding the cases: R. W. Aubrey, M.D., Southwest General Hospital, Middleburg Heights; T. S. Andjus, M.D., Lima Memorial Hospital; G. Dochat, M.D., Akron General Hospital; M. J. Hannibal, M.D., St. John's Hospital, Cleveland; J. W. Tandatrick, M.D., and S. K. Garg, M.D., St. Elizabeth Hospital, Youngstown; and J. L. Berk, M.D., Mt. Sinai Hospital, Cleveland.

*Characteristics of the disease, both clinical and histopathologic, parallel those of other reports in the United States.

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A Cure for Teenage Drug Abuse? We Have It in Ohio

David G. Logan, M.D.

In August 1975, "The Seed," a teenage drug-abuse program, established a satellite operation in Cleveland, Ohio. This Florida-based program has an established record of 90 percent rehabilitation of over 6,000 youthful drug abusers.[1] One hundred and seventy-three "druggies" from Ohio and surrounding states entered the program in the 12 months prior to April 1, 1977. Of these, 162 [93.6 percent] have been successfully treated. A description of the program and my experience as its psychiatric consultant follows.

IN DECEMBER 1974, a group of Cleveland parents concerned about teenage drug abuse offered to pay my travel expenses to Ft. Lauderdale, Florida. I was to visit what they described as an "unusual and effective drug program for adolescents." The program called "The Seed" was touted as a cure, effective in over 90 percent of "druggies." With some reluctance, I agreed to go. I looked forward to a few days of sunshine but fully anticipated the program to be another disappointment. In my experience, nearly every effort in the treatment and prevention of teenage drug abuse had ultimately proved futile.

My skepticism was honestly earned. Since 1969, I had studied the problem intensively and had personally observed a wide variety of treatment approaches. Hot lines, drop-in centers, methadone clinics, therapeutic communities, "multi-modality programs," and free clinics were all too familiar. I had visited programs wherever I traveled: Los Angeles, Chicago, Ann Arbor, Columbus, Washington, D.C., and Dublin, N.H. I had spent several days in New York City, devoting about equal time to programs on either side of the methadone battle line. In the spring of 1973, I studied the British approach to addiction treatment in London.[2] There I visited representatives of various approaches spanning the spectrum from the medical (heroin maintenance) clinics to the relatively anti-establishment, drop-in counseling centers.

My observations have led me to conclude that the immense and expensive emergency effort in this country to contain and treat drug abuse has been effective in only two, small, select groups.

1. The long-term, inner-city, heroin user has found partial salvation in methadone treatment. But his price has been high. Jobs are difficult to hold because daily clinic visits are necessary. Further, addicts resent their loss of freedom, their frequent urinalysis test requirements, and the occasional side-effects of the medication.

2. A small-but-impressive group of successfully rehabilitated drug-dependent persons are members of live-in therapeutic communities, such as Synanon. Again, the expense to the drug-dependent person is a loss of personal freedom. As a result, these programs appeal only to a small number of persons needing help. Unfortunately, therapeutic communities admit their success rates are low. Even these figures are inflated. For statistical purposes, programs only include entrants after they have been enrolled a week or longer. A large, uncounted proportion of programmed applicants leave these programs during their first days of treatment.

Follow-up data for both therapeutic communities and methadone treatment programs is pathetic. Graduation from the therapeutic community and detoxification from methadone rapidly lead to readdiction; both approaches must be viewed as treatment of a chronic condition. Clearly, neither is a cure.

My own effort in Cleveland had covered the entire treatment spectrum. I had been the director of counseling at the Free Clinic for two years, and I founded a "multi-modality program" which included several methadone clinics and a therapeutic community. In my hospital-based psychiatric practice, I had worked with youth individually, in groups, and in family therapy.

Thus, prior to my invitation to Ft. Lauderdale, I had first-hand knowledge of the frustrations involved in an attempt to alleviate the sad burden of the drug-dependent person. Worst of all, the affliction of teenage drug abuse

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Submitted April 29, 1977.

continued its insidious spread through suburban, church-supported, rural, and private schools. The tragedies were poignant in this growing group of drug abusers, and our efforts seemed of no practical value.

An Initial View of The Seed

My arrival at The Seed in Florida was arranged to coincide with a weekly "open meeting." All of the youth currently active in the program (about 150) were present. They sat in audience fashion facing their parents and a small number of guests. The format of the meeting was similar to what I have observed on dozens of occasions subsequently. The kids were singing songs with immense enthusiasm. The meeting then opened formally with explanations on the part of recent program entrants about their selfish behavior at home, their self-destructive use of drugs, and the apparent emptiness of their futures prior to their arrival at The Seed. There were several testimonials by youngsters who had graduated from the program and who were back in the community. Joy shown on the faces of all of the youngsters; and the parents were suffused with a sense of relief and happiness.

It was difficult to believe that these families could have been suffering the same difficulties I had been observing — and treating with so little success — in Cleveland. I recognized the warmth and vigor in each of these kids that I had noted in members of successful therapeutic communities. Yet I was told none of them was trapped in a "live-in" situation. Here in one room were 150 success stories!

I spent the following day with a Cleveland mother who maintained an apartment in Ft. Lauderdale. In addition to her son, there were three other boys sharing her two-bedroom apartment. I observed these adolescents cheerfully sharing the chores. An air of mutual respect pervaded the apartment. They explained that new arrivals to the program are separated from their parents and placed in a home such as this with children of the same sex, similar age, who are further advanced toward recovery. After an initial six weeks, these "newcomers" go home, or if they come from a distant city, they may be assigned to a permanent foster home. They attend Seed meetings daily from 10 AM to 8 PM. After several months in the program, they have usually recovered sufficiently to return to school, attending the Seed program only evenings and weekends.

I spent that evening with the founder of the program, Mr. Art Barker. In his home, Mr. Barker had arranged for me to meet a young boy I had seen about three months before. Charles* was 16 years old when I first met him. He had been expelled from five Cleveland schools for delinquent behavior. He had an extensive record in juvenile court. His parents were entirely unable to enforce curfews, and the local police kept him under surveillance as a known drug seller. He had been treated with a variety of antidepressants by another psychiatrist. In individual and family interviews, I saw the familiar picture of desperation, sadness, and rebellion. I told the parents I could be of no help to the boy, and I advised them to devote their time and love to their other children. I concluded my evaluation with the suggestion that they might find information about The Seed in Ft. Lauderdale. I had heard enthusiastic reports but, at that time, I had no first-hand information.

When Charles appeared in Barker's home, he had changed so dramatically that he had to introduce himself to me. His face was cheerful and full of color. He told me he was enrolled in the local school system and was getting excellent grades. He exuded youthful enthusiasm as he told me his plans for the future. We went over the details of the family meetings we had had; he explained his silence and withdrawal. He had been so upset at seeing his mother cry, and he felt so trapped and responsible for this terrible situation that his impulse had been to flee from the meeting and return to the acceptance of his "druggie" friends.

I now have been following-up this boy's case for 2½ years. I see him approximately every three weeks at open meetings. He graduated from high school easily, is successfully employed, and is in good spirits.

The Seed Program Methods

In August of 1975, The Seed established a program in Ohio with the support of several Cleveland organizations.* The presence of this organization in Cleveland has given me a welcome opportunity to work with its staff and to examine its methods of operation.

An adolescent progresses through the program toward recovery in the following stages:[3]

1. On admision to the program, he is placed in the home of an "old-timer." He is isolated from his home and from his school environment. For ten hours each day, he attends meetings at the program. The new "seedling" is not invited to participate in discussions for the first three days. Instead, he is told to observe the process and listen to the discussion. He then may contribute his own thoughts and observations during a group discussion. The "newcomer" sees his parents only at meetings as described above. Only after he has begun to make progress is he allowed to talk to his parents after open meetings.

2. When the staff has determined that the newcomer has become sufficiently accustomed to new ideas of living with his family and after the family has been encouraged to support this new, positive behavior in their child, he is returned home. After returning home, the youngster is driven to The Seed each day by his parents for the ten-

*Not his real name.

*The Cleveland Foundation, The Catholic Diocese of Cleveland, and The Warner and Swasey Company

hour program. The Seed's staff continues to meet with the family and with the boy or girl as necessary.

3. When the staff feels the youngster is ready for re-exposure to school, he returns to school full-time. Following school, he is met by a parent who drives him directly to The Seed so that afternoons, evenings, and weekends, he continues in the program, avoiding contact with his former drug-using classmates.

4. In the final stage of the program, the boy or girl again is attending school full-time but is only required to come to three evening meetings and one meeting on the weekend. After a period of time of increased exposure to school and social experiences, the youngster will be "graduated."

5. Following graduation, most youngsters continue to attend open meetings whenever they are in town. Additionally, there are optional weekly "graduate raps" where family issues, topics of the day, and other items are discussed.

From this description, it is apparent that one of the major techniques of the program is to remove the adolescent from his peer group. In such school and street peer groups, high priority is placed on a "super cool" attitude toward drug usage, sex, and defiance of the law.

In The Seed itself and in the home of his host "old-timer," the program entrant is immersed in an atmosphere of love. In this foster home, the youthful Seed participants openly express love for each other and an atmosphere of cooperation prevails.

The major activity at The Seed is the "rap." Raps are led by the staff, for the most part, but youngsters who have been in the program for some time may suggest a topic and lead a discussion on it. The groups sit in audience fashion facing the group leader. Participants in the discussion stand when they speak. There is a high priority on honesty, revealing of self, and mutual respect. When the discussion leader feels that he has called on someone who is not displaying these attributes, the person may be asked to sit down. The staff members are exceedingly good at leading this kind of group discussion as they have been trained for many hours by Mr. Barker and other staff members.

The rewards of speaking in front of this highly structured and protected group are seen at each open meeting. Youngsters as young as 10, 11, and 12 years old will stand up and tell a group in clear and forceful terms the nature of the life they have been leading and where they intend to spend their future efforts. Previously self-conscious and affected behavior melts away. Youngsters are eager to suggest songs, perform some newly acquired soft-shoe routine, or contribute in some other manner.

Evaluation

Once the program was established in Cleveland, the staff began referring program applicants to me for psychiatric evaluation. Youngsters with a history of psychiatric treatment or who appeared disturbed were sent to my office accompanied by their parents. In the 12 months prior to April 1, 1977, I interviewed 58 youths and their parents. The outcome of this group evaluation is outlined in the Table. The following points should be noted: (1) Ten youngsters were not accepted. Six had major, diagnosable psychiatric illness; four others were judged untreatable. (2) An additional four, although psychologically acceptable, failed to register. (3) Thus, 44 of the 58 applicants were deemed acceptable and registered. (4) Of this number, 38 (86 percent) are now drug-free, back in school or at work, and are living with their families. (5) As stated previously, outcome measures for drug treatment programs often are based on those applicants who complete a certain number of initial "preentry" days of program adjustment. By this standard, I have seen 40 acceptable program entrants who completed five days at The Seed. An astonishing number, 38 of the 40, or 95 per cent, are doing well.

Experience with 58 Applicants for The Seed Program

Results		Number
Successfully entered program		40
Drug free: doing well on program or back in school	38	
Dropped program: probably returned to drugs	2	
Not accepted		10
Psychiatric illness	6	
Untreatable (suicidal, violent)	4	
Entry failures		8
Failed to register	4	
Left on second day	4	
Left on fifth day	2	

Conclusion

The adolescent drug rehabilitation program called The Seed was founded in Florida by Mr. Art Barker in 1973. Since that time, over 6,000 youthful drug abusers have been treated. When the program was investigated in 1973, over 90 percent of its graduates were found to have been successfully rehabilitated.[1]

The Seed program in Cleveland appears to be an equally successful venture. As physicians, educators, judges, probation officers, and clergy have seen successfully rehabilitated youth return to their communities, referrals have risen steadily. As of this writing, 162 youngsters have been cured of their abuse of drugs. I believe the credibility of the program has been established. In the few years, it should enable many hundreds more of our wayward youth to return to a useful life in the community.

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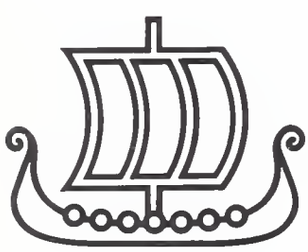
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Prescribing Practices and Postgraduate Education

Noel J. Watson, M.D.
Douglas P. Longenecker, M.D.

INTEREST IN POSTGRADUATE medical education has been increasing constantly. Credits for relicensure (Ohio) and reexamination for specialty board recertification (American Board of Family Practice) contribute to this phenomenon. The result is that physicians will choose more carefully from the array of postgraduate programs available, opting in favor of programs promising high-quality course content rather than first-rate entertainment and a midwinter suntan. The onus not only is on the physician participants but also on the medical educators and practitioners presenting the program to see that the content is pertinent to the practice of medicine and meaningful to the participants' professional growth and development.

Prescribing therapeutic agents comprises a large, and perhaps increasing, part of family practice.[1] Psychotropic drugs are assuming a large part of that prescribing pattern,[2] and the excessive or inappropriate use of antibiotics has been decried.[3] With issues of this nature in mind and in planning an upcoming Ohio State Medical Association presentation, we felt it would be worthwhile to relate the content of the meeting to the educational needs and interests of practicing physicians. This experience is described herein.

Method

A six-part, one-page questionnaire was mailed to 96 members of the voluntary clinical faculty of the Wright State University School of Medicine Department of Family Practice, comprised of general and family practitioners in the Miami Valley area. Questions related to drugs most commonly prescribed, drugs physicians are hesitant to prescribe, drugs about which physicians would like to learn more, and drugs physicians feel they may be prescribing too frequently or inappropriately. Also determined was the length of time since the physicians graduated from medical school and what drugs they may not be prescribing because such drugs were introduced after the physician completed his or her training. The questionnaire was made brief and uncomplicated intentionally so that it would not be time-consuming.

Results

Thirty-nine of 96 physicians replied to the questionnaire, a response rate of 41 percent. Respondents had graduated from medical school between the years of 1935 and 1975, with a *mean* year of graduation of 1958 and a median year of 1963.

The most commonly prescribed drugs by category and in order of frequency were antibiotics, psychotropics (mostly minor tranquilizers), antihypertensives, analgesics, antihistamine-decongestant combinations, cardiac drugs, gastrointestinal agents, anti-inflammatory agents (other than aspirin), expectorants, antidiabetics, and oral contraceptives. In addition, a number of miscellaneous drugs were identified which were not categorized easily. These included bronchodilators, vitamins, muscle relaxants, noncontraceptive estrogens, and others. The breakdown of these categories into individual agents is shown in Table 1. The components are listed in order of frequency.

Because of concern about side-effects, respondents expressed hesitation to prescribe the following agents (listed in order of frequency): phenybutazone, estrogens, amphetamines/anorectics, chemotherapeutic agents, chloramphenicol, monamine oxidase (MAO) inhibitors, oral hypoglycemics, L-dopa, steroids, and oral contraceptives. Numerous others were identified with less frequency, eg gold salts, Flagyl,® Slow-K,® and others.

Respondents expressed an interest in learning more about 36 different drugs or categories of drugs. Those more commonly identified were propranolol, antidepressants, newer antihypertensives (Catapres,® Minipress,® Inderal®), newer antiarthritics (Naprosyn®), antibiotics (not *one* particular agent) and L-dopa. Among those

Dr. Watson, Dayton, Assistant Professor, Department of Family Practice, Wright State University School of Medicine.
Dr. Longenecker, Jackson Center, is currently in private practice. At the time this paper was submitted, he was Professor, Department of Family Practice, Wright State University School of Medicine, Dayton.
Submitted May 17, 1977.

drugs listed in this section in smaller numbers were oral potassium supplements, conjugated estrogens, newer asthma drugs, Questran,® vitamin B_{12}, and many others.

When asked what medications they felt retrospectively they had prescribed too frequently or inappropriately, respondents identified those agents found in Table 2.

Physicians were questioned about what medications they tended not to prescribe because the agents had been introduced since the completion of the physician's medical training. The responses tended to fall into three categories: cardiovascular agents, newer antiarthritics, and antibiotics. In the first group were clonidine hydrochloride (Catapres), prazosin (Minipress), propranolol, ethacrinic acid, and procainamide hydrochloride. The second group of newer antiarthritics, consisted of naproxen (Naprosyn), ibuprofen (Motrin®), and fenoprofen (Nalfon®). The antibiotic group identified in this section included tobramycin, trimethoprim and sulfamethoxazole (Bactrim,® Septra®) carbenicillin, and cefazolin (Ancef®).

When respondents identified specific agents in the questionnaire (as opposed to categories of agents), brand names were specified 69.8 percent of the time and generic names 30.2 percent.

TABLE 1. Most Commonly Prescribed Drugs by Specific Agents

Antibiotics	**Psychotropics**
Penicillin	Diazepam/chlordiazepoxide
Ampicillin	Antidepressants
Tetracycline	Barbiturates
Erythromycin	Meprobamate
Others	Others
Antihypertensives-diuretics	**Analgesics**
Thiazides	Aspirin
Alpha methyldopa	Acetaminophen
Reserpine	Codeine combination (Empirin® compound No. 3)
Furosemide	
Triamterene/hydrochlorothiazide	Propoxyphene
Others	Others
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Laxatives	
Others	

Discussion

The span of graduation years from 1935 to 1975 gives a wide range of experience to our voluntary clinical faculty. This is of greatest interest with respect to this study when considering the responses relating to drugs introduced since 1958 (mean year of graduation) or 1963 (median year). This emphasizes the importance of postgraduate education and evokes admiration for the diligent efforts of our older colleagues to keep abreast of the changes in the field of medicine. We were humbled by two of our respondents who stated that all of the drugs they commonly prescribe have been introduced since their formal training.

We are not surprised that the single most commonly prescribed agent was penicillin. This remains a controversial issue, as evidenced by some respondents who justified their response in parantheses ("for secondarily infected colds"). We are unsure of what a "secondarily infected cold" is: otitis media, streptococcal pharyngitis, pneumonia? We suspect that patient pressure to prescribe antibiotics for the common upper respiratory infection (URI) is still a large factor in the practice of medicine and that this remains a major educational problem for physicians and the lay public alike. This issue probably applies equally to penicillin, ampicillin, and erythromycin.

Ranking second as a group, psychotropic agents, primarily diazepam and other minor tranquilizers, are very widely prescribed. That diazepam is the most widely prescribed psychotropic, has been reported previously.[4] Antidepressants made up about 30 percent of the psychotropic group. We suspect that patients with covert depression, possibly presenting as anxiety or sleep disturbance, are still commonly treated with minor tranquilizers, which may be inappropriate. In fact, anxiety symptoms in depressed patients have been shown to respond better to tricyclic antidepressants than to minor tranquilizers.[5] It should be kept in mind that anecdotal patient acceptance of prescribed agents may not be the key to their appropriateness. In fact, patients generally reply that they feel they are being helped by these agents[2] even though there is evidence that these patients do just as well when antianxiety agents are not available or not used.[6] The extreme impor-

TABLE 2. Drugs Prescribed Too Frequently or Inappropriately

Identified by Multiple Respondents	
Tranquilizers	
Diazepam	Estrogens
Tranquilizers in general	Amphetamines
Chlordiazepoxide	Phenylbutazone
Others	
Antibiotics	
Antibiotics in general	
Penicillin	
Tetracycline	
Others	

Identified by Single Respondents
Diethylpropion HCl (Tenuate)
Steroids
Antidepressants
Vitamins
Alpha Methyldopa
Quinidine
Guanethidine
Laxatives

tance of these concepts is supported by the frequent estimation that some elements of psychologic disturbance is present in a third or more of the patients seen in family practice.[7]

Physician hesitancy to prescribe certain agents seemed to reflect either actual recognized adverse effects of the drugs (phenylbutazone, chemotherapeutic agents, chloamphenical, MAO inhibitors) or recent publicity in the medical literature about their use (estrogens, amphetamines for dieting, oral hypoglycemics, oral contraceptives). Physicians were hesitant to prescribe some agents that also were identified as drugs they would like to learn more about; namely, propranolol, newer antiarthritics, L-dopa, and cancer chemotherapeutic agents.

We were interested in the kinds of insight physicians might have into their past and present prescribing practices. Interestingly, the single specific agent most commonly identified as having been prescribed too frequently was diazepam (Valium®), which was identified in the first section as one of the most frequently prescribed individual agents. Likewise, penicillin was the second most frequently mentioned agent as having been prescribed too frequently by the respondents, yet in the first section, it was identified as the most commonly prescribed drug in the entire study. This reaffirms our impression that most family physicians understand the principles involved but are yielding to other kinds of pressure (patient pressure, fear of undiagnosed bacterial disease in what appears to be an upper respiratory infection or viral syndrome), as stated before.

Other responses concerned drugs that had been prescribed too frequently in the past, which fit with newer information and attitudes about these agents and their potential ill consequences. Examples are estrogens, amphetamines, oral hypoglycemics, steroids. It was reassuring to us that some mechanism does exist, however cumbersome, whereby the busy practitioner is made aware of and responds to new information about drugs.

The questionnaire was assembled in some haste. The primary concern was that it be concise enough so that physicians would reply and that we might obtain the necessary data in time to prepare the pharmacology presentation. In retrospect, the questions could have been somewhat clearer. It would be best to limit responses to a single agent, instead of permitting categories of drugs (eg, "Diuril®" rather than "diuretics"). In addition, respondents were not restricted to prescribable as opposed to "over-the-counter" drugs which lead to some confusion. Respondents used both trade and generic names; we did not feel that any restrictions were necessary in that regard.

Summary

A simple, workable mechanism exists for assaying the prescribing practices and attitudes of a population of physicians. This has been done, reporting the commonly prescribed drugs, as well as identifying physicians' attitudes about side-effects and the need for education. It is suggested that these data could be used in the overall plans for postgraduate, continuing medical education for that group of physicians.

Generic and Trade Names of Drugs

Metronidazole—Flagyl (Searle & Co)
Potassium chloride—Slow-K (CIBA Pharmaceutical Co.)
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THE OHIO STATE Medical Association Clinical and Scientific Specialty Series

Education in Orthopedic Surgery

Paul H. Curtiss, Jr., M.D.

Editor's Note: This article is one of several to acquaint the practicing physician with the role of the various medical specialties in providing total patient care.—*R.L.M.*

BY DEFINITION, orthopedic surgery is defined as "that specialty that includes the investigation, preservation, restoration and development of the form and function of the extremities, spine and associated structures by medical, surgical and physical methods." It would seem logical in presenting the current state of education in orthopedic surgery to relate it to the continuum of orthopedic education as it now exists. It begins with the role of orthopedics in the education of medical students in the musculoskeletal system, proceeds through the period of residency, specialty board certification, and the continuing education of the orthopedic surgeon.

Orthopedics in Medical Schools

At the present time, there are 120 medical schools in the United States. In all of these schools, orthopedic surgery is taught as part of the clinical curriculum although in many schools, orthopedists also teach in areas of basic science, such as anatomy and pathology. In the majority of medical schools, orthopedic surgery is organized as a division in the department of surgery although there is an increasing number of separate departments of orthopedic surgery. The American Academy of Orthopaedic Surgeons, the organization to which essentially all board-certified orthopedists belong, has on three occasions made a very careful study of education in orthopedics. The first was in the publication known as *A National Health Plan for Orthopaedics—A Preliminary Report,* which was developed in 1969 but was not released; the second is documented in a publication entitled *Medical Education as Related to Orthopaedic Surgery,* and the third report is known as *The 601 Study,* which was completed in 1974.

Dr. Curtiss, Columbus, is Chief of the Division of Orthaepedic Surgery, The Ohio State University Hospitals; and Professor of Surgery, The Ohio State University College of Medicine. He has served as Chairman of the Undergraduate Education Committee of The American Academy of Orthopaedic Surgeons.

Received October 27, 1977.

The last reliable data on faculty positions in orthopedic surgery was in 1974. In that year, there was a total of 373 budgeted positions in orthopedic faculty in medical schools, 10 percent of which were unfilled. This difficulty in filling orthopedic faculty positions is a source of continuing concern. As might be expected, the amount of exposure of medical students and curriculum time available for study of the musculoskeletal system varies widely from school to school. This is related to factors such as whether one is dealing with a three- or four-year medical school, the number of faculty available for teaching, and other such factors. The last reliable figures indicate that the heaviest teaching commitments are in the second and third year of the four-year curriculum with most fourth-year teaching done through electives.

A Committee on Undergraduate Education has been active in the American Academy of Orthopaedic Surgeons almost since its beginning in 1931. The committee has been active in attempts to evaluate the curriculum and the teaching of the musculoskeletal system to undergraduates in medical schools in the United States. A notable project of the Committee has been the development of the "500" Series of Sound-Slide-Read Programs, specifically for undergraduate teaching. Thirty-six such programs have been completed, ranging from a series on functional anatomy through the principles of management of clinical problems. All medical schools in the United States were provided the five selected programs initially by the American Academy of Orthopaedic Surgeons and many of them have obtained the entire series. These programs are designed entirely for medical student teaching and have met with an enthusiastic reception.

The most recent activity of the committee is based on the obvious, self-acknowledged fact that much of the clinical information important to the medical student in any discipline is obtained from the resident physician. Recognizing this, the committee is now developing a "short course" in educational techniques to enable the resident physician to become a more effective teacher.

(continued on page 828)

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. ℞ only.

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Orthopedic Surgery *(continued)*

Resident Education in Orthopedic Surgery

The American Board of Orthopaedic Surgery was incorporated in 1934 for the purpose of improving the quality of graduate education in that field, to establish minimum education and training standards, to provide a comprehensive certifying examination, and to certify to the competence of those physicians who have satisfield the requirements of the Board, as a protection to the public and the profession. At the present time, the satisfactory completion of five years of approved postdoctoral education in orthopedic surgery is required. Of this five years, it is mandatory that at least three years be served in an approved program for orthopedic resident education and include a minimum of 12 months of adult orthopedics, six months of children's orthopedics, and nine months training in the treatment of fracture and trauma. In actual practice, most programs have four of the five years devoted to orthopedic surgery, although a few have only three years with the preceding two years in general surgery and other specialties. At the present time, there are about 181 approved orthopedic residency programs in the United States. The majority of these are in university medical centers although a number are based in private hospital systems.

An Orthopaedic-In-Training Examination (the O.I.T.E.) has been offered yearly since 1963 to all orthopedic residents in the United States, the first specialty group to do this. The examination is entirely written and is designed to identify areas of weakness in both the resident's knowledge and in the educational efforts of the resident program. No other use of the results of the O.I.T.E. has been authorized. The residents in each year of training are matched with their peers across the country; this is a valuable experience in itself. For the past two years, the O.I.T.E. has been available to the Fellows of the Academy as a voluntary self-assessment examination.

The certifying examination of the American Board of Orthopaedic Surgery is offered yearly and consists of both a written and an oral examination. In 1964, the American Board of Orthopaedic Surgery and the Office of Research and Medical Education of the University of Illinois entered into a joint research project entitled "The Efficient Use of Medical Manpower." The three main objectives of the study were (1) to identify with greater precision the components of professional competence in orthopedic surgery; (2) to develop methods by which competence may be measured with a degree of reliability and validity that exceed those presently used; and (3) to identify the variables which might influence differential rates of achievement of this competence. This cooperative study with Doctor George E. Miller and his staff at the University of Illinois resulted in a number of important changes in the method of conducting the certifying examination. Space does not permit detailing of these changes but at the time, recommendations from the study gained wide interest among other Boards conducting certifying examinations. At the present time, between 600 and 700 candidates sit for the examination each year.

In addition to conducting the certifying examination, the Residency Review Committee for Orthopaedic Surgery is actively engaged in supervision and review of the approved resident education programs in the United States. Concern over future manpower needs has been a very real concern of the orthopedic community and several studies have been initiated in this regard. Currently, there are no firm data which have affected any changes in the number of residencies or any limitations placed on the number of graduates from the residency programs.

Continuing Education for the Practicing Orthopedist

The American Academy of Orthopedic Surgeons' continuing education efforts date back to its founding in 1933. Meetings of the Academy have been held on an annual basis with scientific papers representing the major educational medium. In 1943, the annual meeting program was supplemented by the introduction of instructional courses, which were based upon selection of specific subjects treated in depth by known experts in each area. These courses, which have continued to be extremely popular, generally run from one to three hours in length. Courses selected by the committee have been published annually since 1944 as "Instructional Course Lectures" and have become an integral part of many libraries, serving both resident and practicing orthopedic surgeons as valuable source material. In 1975, a new concept, "The Summer Institute," was initiated. This is essentially a three- to four-day, "mini" instructional course session. Many innovations are being introduced, however, including video tape presentations and small-group audience participation which is not possible at the larger annual meeting. This has been an exciting and stimulating recent effort on the part of the Academy. A motion picture library was begun following World War II, and a sound-slide library was established in 1950. Programs in the sound-slide library now total nearly 500 titles and the annual rental is about 10,000 exchanges. In 1976, a Committee on Video Tapes was appointed, and already six video-tape productions have been prepared and offered for both sale and rental. In 1962, the Academy continuing education courses were begun. These are sponsored by an Academy committee, produced under the direction of individual course chairmen on subjects of current interest in orthopedics, and have had wide popularity among practicing orthopedists. Plans for a proposed course are submitted to the Committee on Continuing Education of the Academy by a course chairman or another Academy committee and there are no conflicts in the time of year, geographic location, or content of the course. Scheduling is planned up to three years in advance to permit proper balance. Eighteen continuing education courses were conducted in 1977 under the direction of the Committee on Continuing Education.

In 1975, an Orthopedic Self-Assessment Examination was made available to the Fellows of the Academy.

It differs from the O.I.T.E. in that the questions are much more "clinically" based. In addition, an answer booklet and bibliography are returned to the individual who completes the examination for his further education.

Overseeing the general educational activities of the Academy is the Advisory Committee on Education. This committee consists of the chairman of those Academy committees directly concerned with education and provides a valuable overview of the Academy's continuing education efforts.

The field of orthopedic surgery has reason to be proud of the efforts of the Academy and the American Board of Orthopaedic Surgery in educational activities. In many areas, this specialty has been the leader in new concepts of examination and evaluation and in providing relevant and available continuing education material for its Fellows.



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The Ohio State Medical Association Cancer Education Series

The Adjunctive Treatment of Carcinoma

Thomas D. Stevenson, M.D., Columbus

This is the initial article of a monthly series devoted to practical aspects of the diagnosis and management of cancer. These articles in *The Journal* are sponsored by the Ohio Division of the American Cancer Society. It is hoped that the series will bring to the practicing physician brief, practical, diagnostic, and therapeutic information. The contributors have been selected from throughout the State of Ohio because of their expertise and/or interest in the treatment of cancer. We hope that this series proves to be worthwhile and of interest to our professional colleagues.

William A. Newton, Jr., M.D.
Chairman, Cancer Coordinating Committee
The Ohio State Medical Association

Thomas D. Stevenson, M.D.
President
Ohio Division of American Cancer Society

PHYSICIANS ARE painfully aware that even with optimal surgical and/or radiation treatment of the primary site of many types of cancer, recurrence is frequent and the patient is destined to succumb to metastatic disease. Recurrence is due to growth of micrometastases which are undetected or undetectable at the time the patient is treated for the primary tumor.[1] The development of drugs capable of producing regression of some types of cancer, even when advanced, has led to the use of these drugs when the tumor burden is minimal and the chances of ablation of all remaining tumor cells are the greatest. Adjunctive chemotherapy is the the use of anticancer drugs to prevent or delay recurrence in patients who show a high risk for recurrence. This is not a new concept since surgical adjunctive chemotherapy trials were initiated 20 years ago.[2] The results of these initial trials were disappointing, but only single agents were used and the amount of drugs and the duration of treatment were minimal. The development of more potent drugs and the use of multiple-drug regimens has resulted in dramatic improvement in the results of adjunctive chemotherapy and the improved results in certain types of tumors have been widely publicized. Primary care physicians often encounter patients and their families who are willing, and often eager, to try any treatment that could possibly prevent recurrence or spread of a primary cancer. It would seem worthwhile to use adjunctive chemotherapy in all patients at high risk for recurrence of any type of cancer. There are important principles concerning this treatment, however, that must be considered before such treatment is recommended. The first is that adjunctive chemotherapy should be of proved effectiveness. The most meaningful and significant result of any cancer treatment is prolonged survival, and adjunctive chemotherapy that prolongs survival is obviously worthwhile. Adjunctive therapy that delays recurrence but does not significantly prolong survival is of less value. The second principle is that the benefit/risk ratio should be favorable: the short- and long-term side effects should be well-defined and acceptable.

Cancers Affected by Adjunctive Chemotherapy

Based on these principles, one can categorize cancers for which adjunctive chemotherapy has been used into three categories. (See Table.)

The first category includes tumors in which adjunctive chemotherapy results in prolonged survival.[3] As shown in the Table, the cancers in which adjunctive chemotherapy is of greatest benefit are predominantly childhood cancers. These beneficial results are obtained

when the chemotherapeutic regimen is part of a multiple-modality approach which includes adequate surgical treatment and radiation therapy. The omission of adjunctive chemotherapy from the management of these cancers denies the patients the best chance for cure of their disease.

The second category includes cancers in which adjunctive chemotherapy delays recurrence and possibly prolongs survival. The only tumor in this category is carcinoma of the breast. The data clearly indicate that adjunctive chemotherapy has a significant effect in the premenopausal female with axillary lymph nodes positive for metastasis at the time of mastectomy.[4] Adjunctive chemotherapy does not have a dramatic effect in the postmenopausal female, however.

In the third category, one must unfortunately place the majority of common cancers. I am not aware of any data indicating that adjunctive chemotherapy is of proved value in patients with colorectal, lung, genitourinary cancer, or malignant melanoma.[3]

Adjunctive chemotherapy has not had a significant impact on survival or delayed recurrence in patients with these cancers, but clinical trials are continuing. It is most effective when only a small number of viable tumor cells remain; immunotherapy also should be most effective under the same circumstances.

Immunotherapy

Nonspecific immunotherapy has been used alone or in combination with antineoplastic drugs in an attempt to provide greater tumor-cell ablation than can be obtained with either modality alone. So far, the results of immunotherapy have been disappointing. There are no good data indicating a significant improvement in survival with adjunctive immunotherapy or combined chemotherapy.[5] At the present time, immunotherapy remains experimental.

Tumors Treated With Adjunctive Chemotherapy

Show Proved Benefit and Survival Prolonged.
- Wilms' tumor
- Embryonal rhabdomyosarcoma
- Ewing's tumor
- Osteogenic sarcoma

Have Delayed Recurrence and Possible Prolonged Survival
- Carcinoma of breast

Have Neither Delayed Recurrence Nor Prolonged Survival
- Colorectal cancer
- Lung cancer
- Genitourinary cancer
- Malignant melanoma

Adjunctive chemotherapy is a promising area of cancer management and has significantly improved survival in patients with responsive cancers. The primary care physician must be aware of those cancers in which this therapeutic approach is of *proved* benefit and recognize that this approach is unproved in patients with commonly encountered cancers. Consultation with cancer treatment centers and medical oncologists is desirable since clinical trials of new drug combinations may prove to be of benefit in those cancers currently not affected by such treatment. It is strongly recommended that the patient receiving adjunctive chemotherapy be placed on a protocol of a cancer center or a cooperative study group. In this way, meaningful data can be accumulated concerning the value of such treatment. The advances made in the management of pediatric tumors and breast cancer by adjunctive chemotherapy would not have been possible without the activities of cooperative clinical groups.

The combined modality approach with the optimum utilization of surgery, radiation, and chemotherapy has resulted in significant progress in the management of patients with cancer. Hopefully, the development of new, more potent drugs, and of mechanisms of limiting and ameliorating the toxicity of the available agents will result in a greatly expanded role for adjunctive chemotherapy.

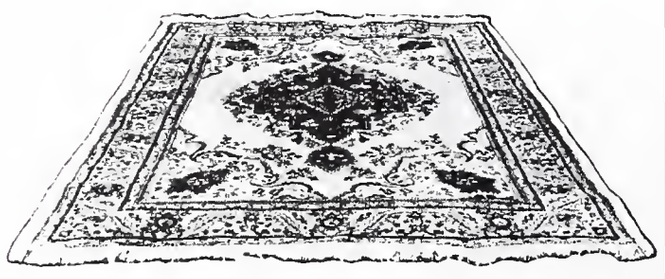
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Legislative Update

the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Probably the most unexamined subject getting political and media attention these days is the repetitively decried "high cost of medical care." To paraphrase an expression, everybody wants to talk about the high cost of medical care, but nobody wants to examine it. The American Medical Association has examined the subject and has broken down the cost factors. This is the first of two articles on the subject. The following are the AMA findings.

The proximate causes of escalating medical costs are largely abstract. They include: (1) strong inflationary pressures in general, for which government itself must shoulder a large share of the blame; (2) remarkable improvements in clinical and technological resources; (3) expansion of benefits and of eligible recipient populations under government health programs; (4) hyped-up demands for services created by space-age improvements, as well as by tax-subsidized programs; (5) longer average life spans, requiring extraordinary amounts of care for chronic illnesses; and (6) other factors, such as soaring professional liability insurance premiums for both hospitals and physicians, costs which must be passed on to patients.

Furthermore, there is hard evidence to support this analysis, much of it provided by government itself. Consider the *Background Book on Medical Care Expenditures, Prices and Costs,* published by the Office of Research and Statistics of the Department of Health, Education, and Welfare and the Social Security Administration. One section is devoted to hospital care— by far the largest part of the medical dollar, and to the steep increase in hospital rates between 1950 and 1974. The book points out that increased efficiency and productivity within the hospital could reduce costs to some extent. The booklet also states that increases in the average expense per patient day in community hospitals result from two major factors: (1) increases in wage rates and prices paid by hospitals, or the additional costs necessary to maintain the same level of services in the face of inflation, and (2) expenditures for improved services, including the cost for more employees and for such expenses as additional equipment and supplies.

The booklet specifically enumerates some of the remarkable changes in the nature and scope of hospital services which have taken place since 1950:

> Facilities and services which were unavailable two decades ago, or were found only in highly sophisticated teaching hospitals, are now offered by many community hospitals.
>
> For example, such services as renal dialysis, open heart surgery, and kidney transplantation either didn't exist or were very rare in 1950.
>
> In addition, hospitals now provide specialized facilities and services for illnesses which were treatable before, but with only limited success, such as intensive care units for victims of heart attacks, severe burns, and traumatic shock.
>
> Finally, hospitals provide many more community services, including rehabilitation services, home care programs, genetic counseling, family planning, and outpatient psychiatric care.

The American Hospital Association President, Alex McMahon of Chicago, said the Association's financial experts estimate that eight new federal regulations will increase hospital costs by $863 million in 1977. He said government officials who want to stop the escalating costs of health care should realize that they are "part of the problem."

A study completed a few years ago at Massachusetts General Hospital revealed that a person suffering a serious heart attack in 1920 would have spent eight weeks in Massachusetts General for a total charge of only $180. In 1930, the patient would have stayed six weeks for about $210. In 1970, the patient would have stayed for only four weeks, at a cost of more than $3,500. However, while the patient's chances for survival were less than two to one in 1920, by 1930 the odds had improved to more than three to one, and by 1970, to more than five to one. Hospital charges have jumped considerably even since 1970, but so have the odds for added health and life for that mythical heart patient.

Medical care was at 184.7 on the Consumer Price Index (CPI) in 1976 (1967 = 100), but it is not true that it is the fastest-rising item in the CPI. Faster-rising items include many essential services. For example, lawyers' charges were at 199.9 on the 1976 CPI; insurance and finance charges were at 196.6; postal charges were at 222.3. Most services pertaining to everyday living are up: having your living room or dining room repainted (225.6), having the house roof reshingled (233.4), having a sink replaced (210.2), having the furnace repaired (207.1), having the washing machine repaired (200.4), repairs of the family auto (189.7), and services of a babysitter for the evening (214.6).

Of course, prices aren't the only things that have gone up. Incomes have risen, too. Per capita income after taxes has more than doubled since 1967, for an index of 202.0 in 1976. Social Security taxes have risen faster than either consumer prices or incomes. An index for the maximum Social Security tax on employees (if the government published one) would have been 308.2 in 1976 (1967 = 100). For 1977, the maximum Social Security tax index would be 332.4.

Next Month: Physician costs— and the true nature of physician income.

The Ohio State Medical Association Medical School Highlights

Innovations Within Tradition

Henry G. Cramblett, M.D., Dean
The Ohio State University College of Medicine

When most practicing physicians look back at their medical education, the basic sciences are remembered as having been endured before work with patients and other "good stuff" could begin. At The Ohio State University College of Medicine, the faculty has undertaken the challenge of making the basic sciences interesting and clinically relevant.

Students entering the College of Medicine choose one of two tracks in which to complete their basic science studies: The Lecture/Discussion Track (L/D) or the Independent Study Program (ISP). The first ISP track of students began their studies in 1970, following development of the program by means of a federal grant in 1969. (Although the grant was awarded in 1969, it should be noted that as early as 1962, Grant Graves, M.D., then Chairman of the Department of Anatomy, began experimenting with the teaching of anatomy by independent study.)

During the seven years that the College of Medicine has had a two-track, body-systems-oriented curriculum, the Independent Study Program has received by far the most publicity, visitors, and national and international acclaim. However, the L/D program, while remaining true to the lecture tradition, has successfully implemented many innovations. Whether these innovations were developed and implemented because of the competition of the Independent Study Program or in spite of it remains an interesting topic for debate. Before expanding on three of the major innovations, it seems appropriate to review the entire medical curriculum.

Lecture/Discussion Phases

The Lecture/Discussion Program is divided into three component parts or phases. Phase I is entitled "Introduction to Medicine." Occurring very early in a student's medical education, this phase gives experience in emergency medicine. prephysical diagnosis, behavioral sciences, and physicians' offices and community hospitals.

Phase II, "The Study of Normal Man," covers the traditional basic science disciplines of anatomy, physiology, and biochemistry by body systems. The initial intent of the body systems program was to adhere to a strict body-systems approach. However, with experience over a seven-year period, the body-system curriculum has been gradually modified to what could be called the quasibody-system curriculum. Those areas not really taught under a body systems format are taught under a discipline approach. Two examples are biochemistry, which juxtaposes its content with anatomy and physiology and gross anatomy which is taught regionally.

The third portion of the Lecture/Discussion Program is Phase III, a nine-month period running from January of Year 1 through mid-September of Year 2. This phase is entitled "Pathophysiology and Manifestations of Diseases" and includes physical diagnosis in its curriculum. Phase III adheres closely to the body-systems approach. After an initial seven weeks of general pathology, pharmacology, and medical microbiology, all body systems are repeated covering pathophysiology, with pharmacology and pathology being taught systematically.

Upon completion of the basic-sciences portion of the curriculum, both L/D and ISP students enter Phase IV, the Clinical Clerkship Program. The Phase IV program includes required clerkships in medicine, psychiatry, surgery, pediatrics, and obstetrics and gynecology. Each is two months in duration. The student also undertakes one month of community medicine, four months of ambulatory medicine, and six months of electives, one month of which may be used for vacation.

Biochemistry Via the Personalized System

The College of Medicine faculty has developed a number of innovations in the Lecture/Discussion Program. In 1973, the Department of Physiological Chemistry, under the chairmanship of David Cornwell, Ph.D., began an experimental program to improve the teaching of biochemistry to medical students. Traditionally, biochemistry has been the most difficult basic science subject to teach because students perceive little clinical relevance in it.

The Department of Physiological Chemistry developed a new system of instruction called the Personalized

System of Instruction. This system can be characterized as being (1) individually paced, (2) mastery oriented, and (3) student tutored. It also uses printed guides for communication of course goals, objectives, and content summaries; and the system includes some lectures for student stimulation and motivation.

The content of the course is broken into 22 study modules. Each study module states the expected objectives to be mastered by the student and a summary of content along with specific references to biochemistry texts. The students study approximately one module per week with 100-percent mastery expected on the quiz given in each module. Those who fail the mastery quizzes are tutored by biochemistry faculty, graduate students, or other medical students who have demonstrated a mastery of biochemistry. Students may retake a quiz up to four times.

The Personalized System of Instruction eliminates all irrelevant content so that only essential concepts are put before the students. This forces the faculty to make hard choices concerning important content. But it is extremely helpful to the student because the amount of material to be learned is limited to the volume that can be mastered within the time allowed. Individual progress through the modules is permitted and, in fact, encouraged. This permits students to balance their study of biochemistry with anatomy and physiology, therefore using their time for maximum benefit.

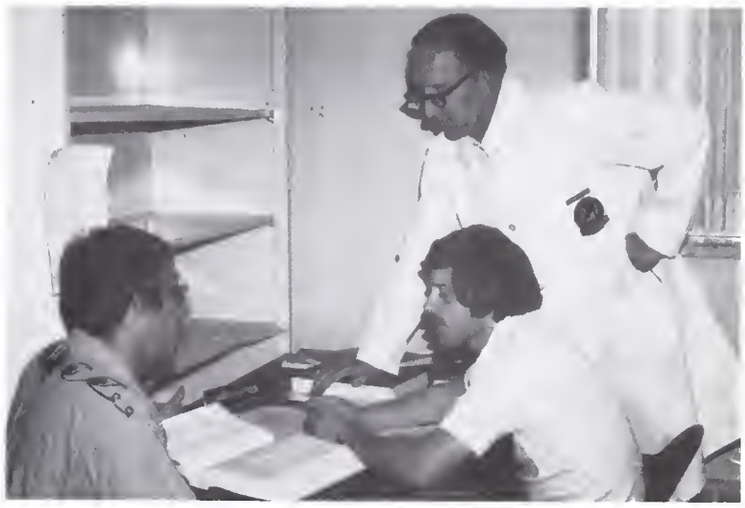
Early experimentation with the Personalized System of Instruction showed that PSI students achieved higher scores than students who participated in the lecture-control groups on shelf copies and regular administrations of Part I of the National Board subtest examination of biochemistry. Feedback from the students regarding their choice between the conventional lecture/discussion and the Personalized System of Instruction showed a clear preference for the nonlecture, self-paced, mastery-oriented, tutorial program. In fact, this innovative instruction has resulted in very high student satisfaction and the highest scores on Part I of the National Boards of any of the six basic science subjects.

Medical Physiology Study System

Until 1976, the Department of Physiology remained rather steadfast in its dependence upon the traditional lecture/discussion format. One problem with this traditional lecture format was that the student behaved passively during the learning process, coming to grips with physiology only before examinations. In many cases, it was not until then that the student realized his deficiencies.

A major innovation developed by the physiology department is a program called Physiology Self-Evaluation Units (PHYSEU). PHYSEU was developed to assure that students maintained an active, continuous involvement in the learning process. This spreads their study efforts more evenly over the 22 weeks of Phase II and enhances their overall mastery of physiology.

PHYSEU consists of 16 computer-based, self-evaluation units. Each evaluation unit has two sections, A and B, containing 25 multiple-choice questions. Generally,



LEFT TO RIGHT: Alberto Leon, James Huttner, and John S. Rieske, Ph.D., of The Ohio State University College of Medicine.

units become available to students on a weekly basis after specific concepts have been presented. Students must perform at or above the 80 percent level in each unit in order to progress to succeeding units. In this manner, areas of weakness are resolved early, largely by student self-study but also by consultation with members of the faculty. Computer scoring and record keeping are maintained only for self-evaluation and informational purposes.

At the present time, PHYSEU provides 800 questions covering the entire range of basic physiological concepts normally provided to medical students. Each question has five possible responses. The student must make a decision for the record: his decision, right or wrong, results in immediate feedback of information. Whether he is correct or wrong, he is told why. The first decision is used for determination of performance level; however, the student is given two or more opportunities to arrive at the correct response to a question, all the time being presented with additional feedback. The entire program contains 4,000 immediate feedback responses.

It is required that all units be completed within the 22-week period. The majority of students learn quickly to plan their activities so that units are completed before examinations which cover the concepts emphasized in PHYSEU.

PHYSEU has been accepted by the medical students as an excellent adjunct to learning. More than 90 percent of the students responding at the end of the 22-week period rated the program as excellent or good. The results of four, in-house examinations averaged approximately 80 percent. Scores on the physiology section of a shelf copy of the National Board Examination were significantly better than those of previous classes. PHYSEU has been revised for use in 1977, and it is anticipated that even better student performance and student satisfaction will be achieved.

Mastery-Based Evaluation

The third significant innovation in the Lecture/Discussion Program is the implementation of a criterion-based evaluation system in both Phases II and III. This

system was developed because ultimate passage or failure of a particular unit of the medical curriculum causes great anxiety among medical students. Debates between faculty and students often arise regarding whether the student has been adequately warned as to his marginal performance and the possibility of failure.

Phase II and Phase III faculty members have faced this issue by retrospectively examining student performance over a three-year period and developing a set of mastery criteria. These written criteria tell a student at the beginning of the course what level of performance is expected in order to achieve a passing grade. The following statement is distributed to students at the beginning of Phase II:

> To successfully pass Phase II, a student must pass all three disciplines with either a percentage score at or above 65 percent or a standard score at or above 370; or pass two disciplines and have a percentage score at or above 55 percent or a standard score at or above 325 in the third discipline. Students who fail two disciplines, or fail to achieve a percentage score at or above 55 percent, or a standard score at or above 325, in any one of the three disciplines will fail Phase II.

After each examination, the student receives a computer-generated printout of his score and the class mean. The passing criteria is also reprinted. Each student's cumulative score on any previous test is also repeated.

This system has markedly reduced student complaints. It has also had a very beneficial effect on the faculty committee which decides student passage or failures, since it alleviates agonizing over where to put the cutoff mark.

Looking Forward

The Ohio State University College of Medicine is fortunate to offer students a choice in learning systems: the Lecture/Discussion Track or the Independent Study Program. The traditional program in the College of Medicine has been revised and modified through a number of instructional techniques to make the Lecture/Discussion Track more interesting and educationally beneficial to the students. Such revision can be found in our departments of physiological chemistry and physiology. This modification, also evident in the present education requirements, is continuing and will certainly encompass other areas eventually.

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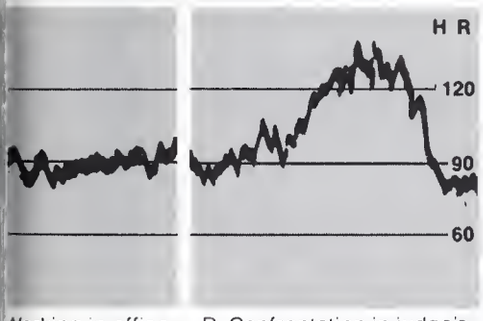
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e energy cost of sex to the art is relatively modest.

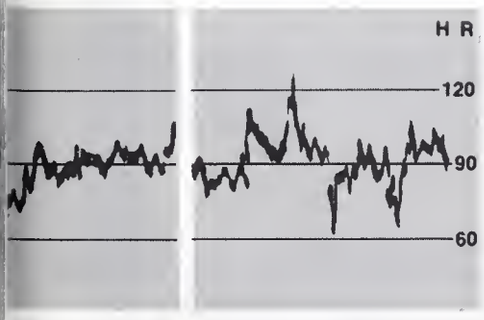
er 80% of post-coronary patients n ultimately resume sexual activity thout serious risk. Hellerstein and eedman demonstrate that mean aximal heart rate during orgasm th spouse (as opposed to extra-arital sex) in 14 post-infarct pa-nts is lower than that during usual cupational activity.

epresentations below of actual KG readings of an attorney, post , illustrate the point:



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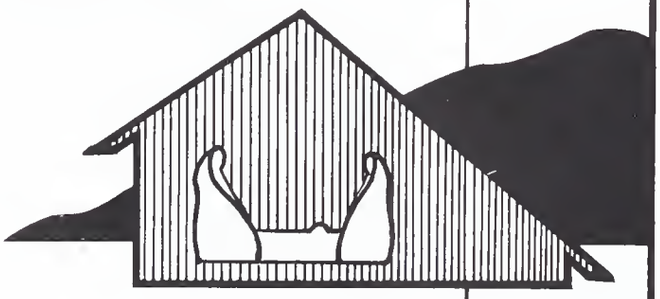
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The Ohio State Medical Association Obituaries

PHILIP ANDREWS, M.D., Dayton; University of Texas Medical Branch, Galveston, Texas, 1947; age 52; died September 7; member OSMA and AMA.

LEONARD BACKIEL, M.D., Northfield; Case Western Reserve University School of Medicine, 1943; age 59; died September 28; member OSMA and AMA.

ALICE M. BUSTIN, M.D., Columbus; Ohio State University College of Medicine, 1931; age 77; died September 30; member OSMA and AMA.

ANDRE CALLOT, M.D., Brecksville; Case Western Reserve University School of Medicine, age 76; died September 30.

ASHER T. CHILDERS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1923; age 85; died July 28; member OSMA and AMA.

WALTER CHILMONCZYK, M.D., Toledo; Harvard Medical School, Boston, Massachusetts, 1948; age 60; died October 8; member OSMA and AMA.

CHRISTOPHER COLOMBI, M.D., Cleveland; Loyola University Stritch School of Medicine, Maywood, Illinois, 1937; age 69; died September 30; member OSMA and AMA.

RUDOLPH F. DIVERS, M.D., Hamilton; Case Western Reserve University School of Medicine, 1935; age 68; died October 4; member OSMA and AMA.

SAMUEL GOLDBLATT, M.D., Fairfield; University of Kansas School of Medicine, Kansas City, 1926; age 75; died September 15; member OSMA and AMA.

HENRY GOLDMAN, M.D., Dayton; Universitat of Wien, Wien, Austria, 1936; age 68; died September 2; member OSMA and AMA.

FREDERICK KAYLOR, M.D., Bellefontaine; Eclectic Medical College, Cincinnati, 1936; age 69; died October 10; member OSMA and AMA.

ZBIGNIEW KUBERCZYK, M.D., Cleveland; Faculte Francaise de Medecine et de Pharmacie de l'Universite, Saint-Joseph, Beyrouth, Lebanon, 1945; age 64; died September 9.

A. MACON LEIGH, M.D., Cleveland; University of Louisville School of Medicine, Louisville, Kentucky, 1938; age 64; died September 27; member OSMA and AMA.

HOWARD V. MISHLER, M.D., Put-in-Bay; St. Louis University School of Medicine, St. Louis, Mo., 1939; age 68; died September 29; member OSMA and AMA.

PAUL FOSTER OVERS, M.D., Elyria; Hahnemann Medical College & Hospital, Philadelphia, Pennsylvania, 1937; age 65; died October 7; member OSMA and AMA.

GEORGE RENNER, JR., M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; age 78; died September 19; member OSMA and AMA.

WILLIAM ROHDENBURG, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; age 80; died August 30; member OSMA and AMA.

DANIEL F. TOTH, M.D., Chillicothe; Case Western Reserve University School of Medicine, 1932; age 70; died August 31; member OSMA and AMA.

HAROLD K. TREECE, M.D., Arlington; Ohio State University College of Medicine, 1941; age 68; died September 26; member OSMA and AMA.

EVERETT TRITTSCHUH, M.D., Lewisburg; Eclectic Medical College, Cincinnati, 1919; age 84; died September 6; member OSMA and AMA.

JOHN M. VAN DYKE, M.D., Longmont, Colorado; Ohio State University College of Medicine, 1924; age 88; died September; member OSMA and AMA.

FRANK B. WEBSTER, M.D., Bellefontaine; Case Western Reserve University School of Medicine, 1933; age 71; died September 3; member OSMA and AMA.

EDWARD E. WHITE, M.D., Van Wert; Ohio State University College of Medicine, 1951; age 55; died April 4; member OSMA.

NEW MEMBERS

CUYAHOGA (Cleveland unless noted)
Jose S. Arias
Fekri R. Aziz
Leslie Bakos, Northfield
Marc Feldman
Edward E. H. Lao
Pareshkumar A. Patel
Martin I. Saltzman
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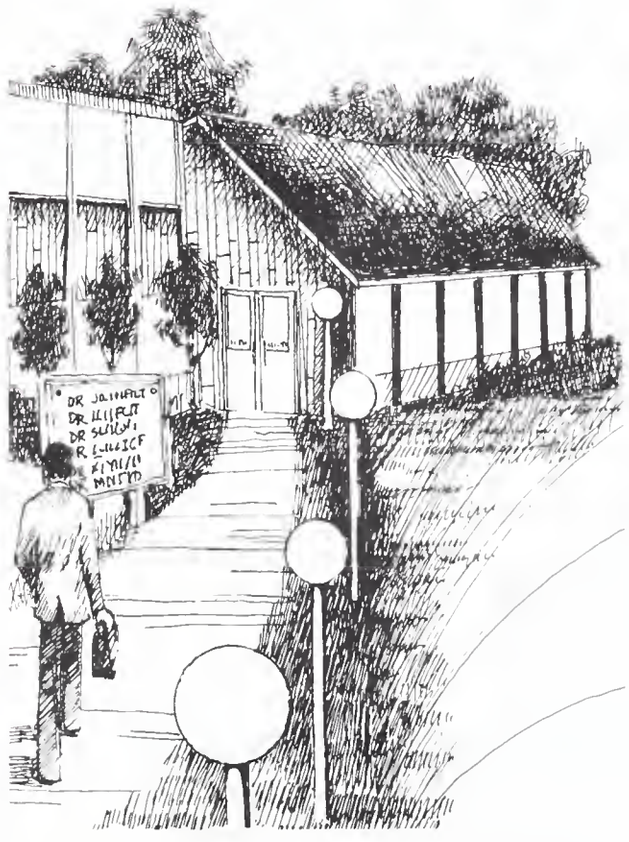
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Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Diagnostic Drug Bill Critically Close In Senate Rules Committee

The OSMA's long battle to defeat SB 163, which would allow optometrists to use "diagnostic drugs," reached a critical stage last month. In a surprise move, the Senate Rules Committee held a vote on Tuesday, November 15, to allow the bill to be considered on the Senate floor. Sen. Morris Jackson's attempt to place the bill on the calendar failed by one vote. Although the Ohio Optometric Association has placed continuous personal pressure on members of the Senate to place the bill on the Senate floor before the first of the year, this was the first formal vote in the Rules Committee in four months.

The optometrists tried again the next day to get SB 163 on the calendar, but were unable to get the six votes they needed. There were five votes against reporting the measure. The following senators supported the OSMA position of opposition to the bill: Marigene Valiquette (D-Toledo), Charles Butts (D-Cleveland), Anthony Calabrese (D-Cleveland), Tony Hall (D-Dayton), and Michael Maloney (R-Cincinnati). The opposition of these senators, four of whom are Democrats, made the difference. These Democrats are opposing the Assistant President Pro Tempore of the Senate, Morris Jackson, the sponsor of the bill.

Two members of the Rules Committee remain undecided on whether to report SB 163. Senators Harry Meshel (D-Youngstown) and Theodore Gray (R-Columbus) could be the critical votes on whether or not the bill is reported. Sen. Oliver Ocasek, President Pro Tempore of the Senate and Chairman of the Rules Committee, has voted once for the bill, but abstained in Wednesday's critical vote. Sen. Ocasek has to balance his responsibilities as leader of the Senate with his personal feelings on this bill. He has indicated throughout this fight that if Senator Jackson and the Ohio Optometric Association prove that they have the votes on the floor of the Senate, he will vote to move the bill from Rules. The Optometric Association will be trying to lock up votes for SB 163 between now and the first of the year.

Several senators have informed the OSMA Department of State Legislation that they have received very few letters or personal contacts on this issue from OSMA members. The senators have also told us that the members of the Ohio Optometric Association have been working furiously with each individual senator attempting to secure passage for SB 163. The OSMA Department of State Legislation cannot stop this bill alone. The OSMA members must increase personal contact with their legislators. You should attempt to ascertain whether or not the legislator needs more information on the issue and whether the legislator has a firm position for or against the bill. This information should be called into the OSMA Department of State Legislation (614/228-6971).

Anesthesia Assistant Bill Moves From House Judiciary

The House Judiciary Committee favorably recommended SB 130 (Jackson, D-Cleveland), the somewhat-controversial anesthesia assistant bill, to the House Rules Committee to be scheduled for a vote by the full House. The bill creates a statutory exemption from the Medical Practice Act for university-trained anesthesia assistants to administer anesthesia under the direct supervision of an anesthesiologist. This restriction was modified by an amendment included in the House Committee at the request of the bill's supporters. SB 130 is a legislative response to the Ohio State Medical Board Opinion that present Ohio law does not permit anesthesia assistants to administer anesthesia.

Mental Health Law Revisions Go To Governor

The Ohio Senate unanimously approved and sent to the Governor HB 725 (Leonard, D-Dayton), revising last session's HB 244, the mentally-ill patients' "bill of rights" and commitment procedures act. The OSMA greatly appreciates the assistance Rep. Paul Leonard provided in ensuring swift action by the Senate. Rep. Leonard was instrumental in stopping the Ohio Psychological Association's attempt to inject a damaging amendment in the bill. HB 725 will simplify the commitment procedure by making the probable-cause hearing informal and by permitting a physician to testify by written deposition with adequate documentation. The OSMA Mental Health Committee members Max Graves, M.D. (Dayton), and George Harding, Jr., M.D. (Columbus), as well as OSMA staff member Robert Clinger, deserve a word of thanks for their assistance on HB 725.

Classified Ads

Rates: $2 per line. Display classified: $4 per line. (1978 Rates: $3 and $5 respectively.) Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5.00 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 5th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal,*** 600 South High Street, Columbus, Ohio 43215.

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FOR RENT: South End, Cols. Estab. G.P. office; 4 rms., central a/c, parking. Phone 614/224-6972 or 231-1987.

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UNEXPECTED OPENING: In obstetrics and gynecology for a first-year resident (Grad II). Seven-hundred bed hospital with medical school affiliation known for its postgraduate medical education in all phases of medicine. Position available July 1, 1978. Reply Box 816, c/o Ohio State Medical Journal.

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CINCINNATI, OHIO: Emergency department director for 650+-bed hospital. Other full-time positions available. Starting salary $55,000 plus insurance package, malpractice, pension, and four-weeks paid time off. Contact Medical Health Services, Inc., 5002 Ridge Avenue, Cincinnati, Ohio 45209, phone: 513/631-0200.

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PROFESSIONAL OFFICE: Warren, Ohio. Approximately 1,000 sq. ft. Off-street parking. Will subdivide to suit tenant. Ideal for general practitioner or internist. Laboratory and surgeon in building. Contact: Physicians & Surgeons Laboratory, 210 Scott St., Warren, Ohio 44483, phone 216/395-3888 or 889-2538.

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Ohio license and board-eligible or board-certified in psychiatry and neurology required. Salary range $40,000-$45,000. Liberal fringe benefits and retirement plan. Scenic area of Ohio. Outstanding recreational facilities in vicinity. Hospital located on southern border of Ohio. Population 26,000. Call or write Henry Hogan, M.D., Medical Director, Portsmouth Receiving Hospital, 25th and Elmwood Road, Portsmouth 45662, phone: 614/354-2804.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL. Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

FAMILY PRACTICE: Existing general practices need new partners or associates. Top medical community. Excellent general hospital. Offices and cross coverage available. Contact: ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302, telephone: 614/382-8211 or 382-3442 any time.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

EMERGENCY DEPARTMENT PHYSICIAN-CLEVELAND, OHIO: New emergency group desires career-minded emergency physicians. Opportunity is unlimited. Superior starting salary; vocational and educational leave; malpractice and hospital insurances paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal. M.D., President, Medical Emergency Services, Inc., phone: 216/398-4141 ext. 388, or 216/831-4095.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

MARION, INDIANA: One internist, board eligible or certified. Permanent license any state required. Salary open to $38,000 depending on qualifications and experience. Special bonus pay of about $6,000 available. 40-hour work week, 30 days vacation, 15 days paid sick leave, 9 paid holidays, low-cost life and health insurance, excellent retirement plan. Moving expenses paid. Contact Frank J. Salvati, M.D., Chief of Staff, VA Hospital, Marion, Indiana 46952. Phone 317/674-3321, collect.

EQUAL OPPORTUNITY EMPLOYER

BOARD-ELIGIBLE PEDIATRICIAN: Available to serve as locum tenens in the greater Cincinnati area during January-March 1978. Reply Box 818 c/o Ohio State Medical Journal.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

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EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Avenue, Willoughby, Ohio 44094, phone: 216/946-4546.

PSYCHIATRIST: For community mental health center using case-manager model. Begin $41,600. Board eligible. 32 hours per week. Private practice allowable. Liberal fringes. Moving expenses. Open October 1, 1977. Resume/three reference letters to Personnel, Scioto Paint Valley Mental Health Center, 50 Pohlman Road, Chillicothe, Ohio 45601, telephone 614/775-1260.

EQUAL OPPORTUNITY EMPLOYER

FAMILY PHYSICIANS WANTED: One or two, resident graduates or board eligible or certified to join two-man group. Large office, semi-rural small town, local college, good schools, excellent 325-bed local community hospital 35 miles from Columbus, Ohio. Great place to practice, live and raise a family. Granville Medical Center, Inc., Granville, Ohio, 43023, phone: 614/587-0115.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA,* will expire on December 31, 1977. Here's how to renew:

Mail your dues now to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA if your County Society has asked OSMA to direct bill for all three levels of dues on behalf of the Society.

OSMA dues are $125. AMA membership dues are $250. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are $50. OMPAC-AMPAC membership is recommended.

Member-in-Training— OSMA membership dues are $20. Membership entitles physician to all privileges including the right to vote and hold office.

Student Membership— a category of membership for full-time students enrolled in medical schools approved by the AMA. OSMA dues are $15.

Many members will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office. That office will certify AMA dues. OMPAC-AMPAC dues will be forwarded to OMPAC Headquarters.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram* and *Your Doctor Reports,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News.*

The member who becomes eligible for exemption from dues, because of retirement or disability, should notify the Secretary-Treasurer of his County Medical Society. After exemption has been established, it is automatically renewed annually, unless the status changes.

For further information on medical society membership, contact:
Mrs. Katherine Wisse, OSMA Comptroller, telephone: 614/228-6971.

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